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ABSTRACT

The final report of a 3 year federally funded project for neurologically handicapped children focuses on accomplishments in the following nine areas: direct and supplementary services for children's services, parent/family participation, assessment of child progress, inservice training for project staff, training for personnel from other programs and agencies, demonstration and dissemination activities, coordination with other agencies, continuation and replication, and the project's advisory council. The bulk of the document is composed of appended material, including data on diagnosis and evaluation, parent training, classroom skill development and behavior, inservice training, incidence, and finance. (CL)

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EC

3rd YEAR FINAL REPORT

REPORT PERIOD 1978-1979

BUREAU OF EDUCATION FOR THE HANDICAPPED
HANDICAPPED CHILDRENS EARLY EDUCATION PROGRAM

CHILD NEUROLOGY CLINIC

GOOD SAMARITAN HOSPITAL & MEDICAL CENTER
PORTLAND, OREGON

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CHILD NEUROLOGY CLINIC

2222 N.W. Lovejoy, Suite 361, Portland OR 97210 (503) 229-7220

Mr. Ed Sontag, Chief
Program Development Branch
Bureau of Education for the Handicapped
HCEEP
Donohoe Building, Room 3123
400 Maryland Ave., S.W.
Washington, D.C.

Dear Mr. Sontag,

We are submitting our Annual Program Performance Report for the third year of our demonstration project. We feel that this report accurately reflects those activities that we have been involved with during the past year. Some of the objectives specified for the project have been completed in earlier years and, as such, are not discussed in length in this report. Reference to earlier reports has been kept to a minimum, however.

We would like to express our appreciation for your continued interest and support in our efforts to provide services to handicapped children and their families during the past three years. Such support has been immensely helpful in allowing us to develop a program serving a broad range of needs. With the completion of this three year project we find that we are in a postition to continue with many of these services at a level which would have been unattainable without your support.

We look forward to continued involvement with the Bureau of Education for the Handicapped through participation in other activities for which we have recived funding. Again, thank you for your interest and support.

Cordially,

Robert M. Shook
Administrative Director
Child Neurology Clinic

RMS:jcm

CHILD NEUROLOGY CLINIC

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Ed Sontag, Chief
Program Development Branch
Washington, D.C.

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PROGRAM PERFORMANCE REPORT

PART I

CERTIFICATION

OFFICE OF EDUCATION
WASHINGTON, D.C. 20202

PROGRAM PERFORMANCE REPORT (Discretionary Grants)

FORM APPROVED
OMB NO. 51-R1091

Further monies or other benefits may be, but will not necessarily be, withheld under this program unless this report is completed and filed as required by existing law and regulations *(45 CFR 121, GSA FMC 74-7)*.

Part I
All grantees with awards from programs listed under "General Instructions" above respond.

1. Date of Report:	2. Grant Number:
10/25/79	G007602087
3. Period of Report: From:	**To:**
7/1/78	6/30/79

4. Grantee Name and Descriptive Name of Project:

Child Neurology Clinic
Good Samaritan Hospital: Educational Training Unit for Neurologically Handicapped Children

Certification: I certify that to the best of my knowledge and belief this report *(consisting of this and subsequent pages and attachments)* is correct and complete in all respects, except as may be specifically noted herein.

Typed Name of Project Director(s) or Principal Investigator(s):	Signature of Project Director(s) or Principal Investigator(s):
Robert M. Shook	Robert M. Shook

Part II *("Accomplishment" Reporting)*

A. All grantees, except for those with awards under 13.443 are to respond to this Section A. Grantees under 13.443 go to B of Part II.

All grantees with awards under 13.444 except those supported solely for "Outreach" activities are to follow the organization of categories listed below in presenting their performance reports. The categories are based on activities common to all Early Childhood projects with the exception noted above for projects solely supported for outreach activities.

(1) Direct and Supplementary Services for Children's Services
(2) Parent/Family Participation
(3) Assessment of Child's Progress
(4) Inservice Training for Project Staff
(5) Training for Personnel from other Programs or Agencies
(6) Demonstration and Dissemination Activities
(7) Coordination with other Agencies
(8) Continuation and Replication

The grant application for programs 13.445, 13.446, 13.450, and 13.520 provided for the following functions or activities as categorical headings in the budget and narrative sections:

Research and Development
Demonstration/Service
Evaluation
Dissemination
Preservice/Inservice Training

Programs 13.451, and 13.452 do not usually require a breakout since the primary function or activity is intrinsic to the respective program.

For each of the above programs, functions, or activities *(as well as those of special import for certain programs; e.g., replication, advisory councils, parent involvement)* discuss the objectives and subobjectives presented in the approved application *(in narrative format)* in terms of:

(a) Accomplishments and milestones met.
(b) Slippages in attainment and reasons for the slippages.

Refer back to your application and utilize your quantitative quarterly projections, scheduled chronological order and target dates, and data collected and maintained as well as criteria and methodologies used to evaluate results for (a) and (b). For grantees under 13.444, in discussing training or personnel from other programs, include descriptions of types of training, institutions or organizations involved, and numbers of trainees and hours of training received.

Also highlight those phases of the plans of action presented in your application that proved most successful, as well as those that upon implementation did not appear fruitful. NOTE: Outreach grantees are to discuss accomplishments and slippages in terms of replication and stimulation of services, resources provided and field testing and dissemination and training in terms of types of personnel receiving training and the number of hours involved.

Grantees finishing this portion of Part II, go to C of Part II.

B. Reporting for Grantees under 13.443 *(Research and Demonstration)*.

Discuss major activities carried out, major departures from the original plan, problems encountered, significant preliminary findings, results, and a description and evaluation of any final product. Either include copies of, or discuss: information materials released: reports in newspapers, maga-

PART II

ACCOMPLISHMENT REPORTING

A. DIRECT AND SUPPLEMENTARY SERVICES FOR CHILDREN'S SERVICES

Objectives	Activities	Evaluation	Outcome
1. To continue to provide necessary medical, psychological and educational direct services for children in the project.	1. Maintain current staff competencies in psychological and educational services areas.	1. Number of children receiving medical, psychological and educational services in project.	1. See Section 1 - Diagnosis and Evaluation data, Table 1.
2. To expand the number of direct services available to children in the project area.	2. To establish relationships between the Child Neurology Clinic and existing service areas in the Portland Metropolitan area.	2. Documentation describing the relationship and subsequent impact upon children who enter project.	2. See Section 1 - Diagnosis and Evaluation data.
3. To continue to provide the necessary supplementary service.	3. To continue to utilize the 27 agencies that were identified during first year of project as appropriate.	3. Number of children referred for supplementary services.	3. See Section 1 - Diagnosis and Evaluation data, Table 1.

B. PARENT/FAMILY PARTICIPATION

Objectives	Activities	Evaluation	Outcome
4. To expand the current caseload to maximum of 20 per parent trainer.	4. Notify referral agencies concerning the existence of the parent training program.	4. Number of families served by each parent trainer during the last month of the report period.	4. Forty-two families were seen by the parent trainers during the last month of the reporting period.
5. To maintain current involvement in state-wide parent training network.	5. Participate in Teaching Research conducted parent training workshops.	5. Number of parent training workshops that Child Neurology Clinic staff participated in.	5. Child Neurology Clinic parent trainers met informally with parent trainers from other programs on a case-by-case basis.
6. To increase the number of parent conducted programs supervised by classroom teachers to average of one per family.	6. Establish expectations on part of staff and parents through conference.	6. Number of parent directed programs conducted per family.	6. Families are conducting an average of 3 programs each.
	6. Training parents in the elements of contingency management data collection.	6. Sample programs conducted by parents.	6. See Section ii - Parent Training.
7. To develop alternative parent training techniques or models.	7. Developing the volunteer, modeling and home centered models as alternatives to center based model.	7. The number of parents who received training in each of the models.	7. See Section ii - Parent Training.
		7. Sample programs conducted by parents in each model.	7. See Section ii - Parent Training.

C. ASSESSMENT OF CHILD'S PROGRESS

Objectives	Activities	Evaluation	Outcome
8. To increase enrollment of infants (0-18 months) to maximum of 12.	8. Notify existing referral agencies. 8. Screen and enroll appropriate population.	8. Average number of infants enrolled during the project year.	8. Twenty-five enrolled.
9. To increase enrollment of toddlers (18-36 months) to maximum of 12.	9. Notify existing referral agencies. 9. Screen and enroll appropriate population.	9. Average number of toddlers enrolled during the project year.	9. Twelve enrolled.
10. To increase enrollment of preschool (3-6 years) to maximum of 24.	10. Notify existing referral agencies. 10. Screen and enroll appropriate population.	10. Average number of preschoolers enrolled during the project year.	10. Twelve enrolled.
11. To baseline each child's performance in the following areas: self-help, language, motor, social skills, and academic achievement.	11. Pretest each child in the five program areas.	11. The baseline levels for each child, for each intervention program will be presented by skill area.	11. See Section iii - Classroom data.
12. Develop individual prescriptive programs based on baseline measurement.	12. Design individual prescriptive program based upon appropriate specification of: 1) behavior to be learned; 2) cues; and 3) consequences.	12. The titles of individual prescriptive programs will be presented along with current level of performance.	12. See Section iii - Classroom data.
13. To evaluate progress in individualized prescriptive program.	13. Continuous updating of programs.	13. Comparisons will be made between the child's current level of performance and his pre-treatment baseline.	13. See Section iii - Classroom data.

C. ASSESSMENT OF CHILD'S PROGRESS (cont.)

Objectives	Activities	Evaluation	Outcome
14. To identify child's inappropriate behaviors through baseline techniques.	14. Define behavior, specific context in which behavior occurs and record.	14. Baseline data for each inappropriate behavior will be presented.	14. See Section iii - Classroom data.
15. Establish remedial programs for identified inappropriate behavior.	15. Design intervention programs based upon successive approximations and contingencies management techniques.	15. The remedial programs will presented for each inappropriate behavior.	15. See Section iii - Classroom data.
16. To explore the use of EEG telemetry as a technique to assist classroom teacher and parents in providing more effective intervention.	16. Adapt presently available EEG telemetry to classroom environment obtaining services of EEG telemetry and medical backup.	16. Each time the telemetry is utilized in the classroom the purpose for its utilization along with the outcome will be documented.	16. Telemetry was utilized 13 times in the classrooms during the project year to document behavioral coorelates to neurological impairments.
17. To increase participation by medical staff in monitoring drugs and neurological states.	17. Develop contracts with existing medical personnel to insure participation.	17. Contract will be presented.	17. Working relationships have been developed specifically with a child psychiatrist, a pediatric neurologist, pediatricians and neurologists.
18. To complete diagnosis and evaluation on children and adolescents 6-21 years.	18. Utilize existing tracking system to insure complete diagnostic workup.	18. Number of adolescents receiving diagnostic and evaluation services.	18. See Section i - Diagnosis and Elvaluation data, Table 1.
		18. Sample summary reports.	18. See Section i - Diagnosis and Evaluation data, Appendix A.

C. ASSESSMENT OF CHILD'S PROGRESS (cont.)

Objectives	Activities	Evaluation	Outcome
19. To translate diagnostic and evaluation activities into workable treatment strategies implemented by public school classroom teacher.	19. Based upon D/E activities formulate recommendations in behavioral terms.	19. Samples of the reports shared with the public school teacher. 19. Number of visits made by Child Neurology Clinic to consult with public school teachers.	19. See Section 1 - Diagnosis and Evaluation data, Appendix A.
20. To continue consultant between Child Neurology Clinic staff and public classroom teacher to insure implementation of intervention strategies.	20. Maintain current level.	20. Number of visits made by Child Neurology Clinic staff.	20. 182 consultations were made.

D. INSERVICE TRAINING FOR PROJECT STAFF

Objectives	Activities	Evaluation	Outcome
21. To provide inservice training to Child Neurology Clinic staff in area of training of professional and para/professional personnel.	21. Contract with Teaching Research for training.	21. The evaluation of the training effort will be contained in a report written by Teaching Research.	21. Completed during first 6 months by the project year, see semi-annual report.
22. To explore and/or participate in other inservice training programs as dictated by program needs.	22. Identify staff deficits in terms of child needs.	22. Statement of deficit to be remediated by participation in specific inservice.	22. Completed during first and second project years.
	22. Identify inservice training efforts which will remediate staff deficits.	22. Number of inservice training sessions attended.	22. Completed during first and second project years.
	22. Participate in identified inservice training program.	22. Written evaluation by participating Child Neurology Clinic staff as to relevancy of inservice program.	22. Completed during first and second project years.

E. TRAINING FOR PERSONNEL FROM OTHER PROGRAMS OR AGENCIES

Objectives	Activities	Evaluation	Outcome
23. To explore feasibility of establishing a training consortium between Child Neurology Clinic and Teaching Research Division (Exceptional Child Research Program).	23. Establish meetings with Teaching Research. 23. Use meetings to establish goals and objectives of consortium.	23. Dates of meetings with Teaching Research. 23. Statement of agreement to cooperate along with operational plan.	23. Completed during first 6 months of the project year, see semi-annual report. 23. Completed during first 6 months of the project year, see semi-annual report.
24. To plan, develop and conduct one (1) joint workshop between Child Neurology Clinic and Teaching Research for classroom teachers.	24. Reach agreement with Teaching Research regarding dates, topics to be covered, and staff responsible for conducting workshop. 24. Conduct workshop.	24. The agenda of the workshop will be presented along with number of participants.	24. Completed during first 6 months of the project year, see semi-annual report.

F. DEMONSTRATION AND DISSEMINATION ACTIVITIES

Objectives	Activities	Evaluation	Outcome
25. To communicate the activities and findings of this program to other early childhood programs in the state, region and nation.	25. Any and all instruments will be sufficiently documented for distribution to other early childhood projects.	25. Number of instruments distributed.	25. Completed development of 3rd and started 4th Parent Training slide/tape presentation to be distributed statewide; the Child Neurology Clinic training manual was distributed to various programs throughout the region.
	25. The Child Neurology Clinic staff will publish two or more documents describing the early childhood model.	25. Number of publications.	25. Chapter titled "Effective Parent Training" published in "Toward Restrictive Environments". Child Neurology Clinic Training Manual in process of revision for republication - "Diagnostic Prescriptive Classroom Model".
	25. The Child Neurology Clinic staff will formally present two or more presentations at state, regional, and/or national conferences.	25. Number of formal presentations at state, regional, and national conferences.	25. 11 formal presentations were made.

G. COORDINATION WITH OTHER AGENCIES

Objectives	Activities	Evaluation	Outcome
26. To communicate with state educational agencies in providing full educational opportunities (P.L. 94-142).	26. Ongoing participation and involvement with planners and implementers of state master plan.	26. Brief narrative describing role of Child Neurology Clinic in state master plan.	26. Child Neurology Clinic to function as a regional facility in maintaining classroom programs for neurologically impaired and developmentally delayed children. To work in conjunction with Portland Public Schools and Multnomah County Education Service District to maintain a classroom program including medical, behavior management, and skill development components.
27. To coordinate with other agencies serving handicapped infants and children.	27. Regularly scheduled meetings with early childhood programs in the Portland Metropolitan area.	27. List of meeting dates and agendas.	27. Clinic staff met with staff from 24 service agencies, educational programs, and health organizations during the project year.
28. The continuation of present referral procedures between medical community and Child Neurology Clinic.	28. Regular communication in medical association meetings.	28. Number of referrals, by source will be presented.	28. See Section 1 - Diagnosis and Evaluation data, Tables 2 and 3.

H. CONTINUATION AND REPLICATION

Objectives	Activities	Evaluation	Outcome
29. To encourage and assist in the replication of the Child Neurology Clinic in other early childhood programs throughout the state, region and nation.	29. All instruments, curriculum, evaluation strategies and other materials used in the center will be packaged for use in other settings. 29. Notification of other early childhood programs as to the soft ware resources available at the Child Neurology Clinic. 29. Development of competency based staff training programs for those early childhood projects, requesting assistance in replicating the Child Neurology Clinic model.	29. The number of early childhood projects that replicate all or portions of the Child Neurology Clinic - Teaching Research Model will be documented.	29. See Section V, Training for Personnel from Other Agencies.

I. ADVISORY COUNCIL

Objectives	Activities	Evaluation	Outcome
30. To maintain an active Advisory Council of which 25% of participants will be parent/consumers.	30. Two formal Advisory Council meetings will be held.	30. The agendas of the Advisory Council meetings will be presented.	30. Advisory Council members visited the project on a informal and individual basis as expertise was required. Programmatic feedback was provided on an informal basis by the individual members of the Advisory Council following each site visit.
	30. Individual Council members will be scheduled for two on-site visitations.	30. The individual site visit reports from each member of the Advisory Council will be presented.	

SECTION 1

DIAGNOSIS AND EVALUATION

DIAGNOSIS AND EVALUATION

The Child Neurology Clinic provides comprehensive diagnostic and evaluation services to children. This service constitutes a major component of the Clinic services. The Clinic employs a transdisciplinary team to perform these evaluations including psychologists, education specialists, social workers, physical therapist, occupational therapist, speech pathologist, and other professional consultants. The transdisciplinary model brings together with a common treatment philosophy, common language, and common treatment goals.

Diagnostic and evaluation services may include one or several of those assessment areas mentioned. A diagnostic interview would be performed if it had been determined by the intake team that an overall family assessment was necessary. These assessments are completed for 93% of all clients. Developmental assessments would be performed to determine individual levels of functioning with respect to self-help skills, cognitive skills, motor skills, and language skills. A psychological assessment would be performed to determine level of intellectual competence to examine personality functioning and to identify behavioral correlates relating to the referral problems. A physical therapy evaluation would be performed to evaluate gross and fine motor skill levels. Additionally, the physical therapist routinely screens children age 5 and under. Other assessments such as audiological screenings and psychiatry are provided on a consultant basis and would be included in the diagnostic and evaluation workup if deemed necessary by the intake team.

During the intake process all referrals are screened as to appropriateness for Clinic services and all appropriate evaluations are scheduled. A typical evaluation of a preschool child, for example, might include a developmental evaluation using such instruments as the Bayley Scale of Infant Development, the Boyd Developmental Progress Scale, the Stanford-Binet, and the McCarthy Scales of Children's Abilities. In addition, it would include a comprehensive physical therapy evaluation, performed by a licensed physical therapist and a diagnostic interview performed by a social worker (M.S.W.). A typical evaluation for a school age child would include a diagnostic interview, a psychological evaluation, and an educational assessment.

Following the diagnostic workup the transdisciplinary treatment team meets to evaluate the data, schedule additional diagnostic evaluations, specify areas of intervention, and identify program resources. During the treatment team meeting a primary, secondary, and suspected diagnosis are made. Intervention goals are then established and prioritized according to the information available. These intervention goals are then integrated into a treatment plan, the result of which are later shared with the parents at a parent conference and then, with the parents' permission, other professionals working with the family and child.

After identification of problem areas and intervention goals, specific service areas are identified. These service activities are examined with respect to services offered within the Child Neurology Clinic such as the data based developmental classrooms for infants, toddlers, and perschool age children, parent training services, physical therapy, and educational consultations. If additional services are required which are not available directly through the Clinic or Clinic collateral services, referrals will be made to appropriate community agencies.

As mentioned previously, following the treatment team meeting a parent conference is scheduled. The parent conference provides an opportunity for the diagnostic recommendations to be shared with the parents and for the parents to have input into the prioritizing of treatment goals. The Child Neurology Clinic adheres to a policy of sharing the information obtained through the transdisciplinary evaluations with the family and also of including them in the proposed treatment plan.

A preschool age child might typically be referred for physical therapy, placement in a development classroom, and parent training. All of these services are available to the family through the Child Neurology Clinic. A typical set of recommendations and referrals for a school age child include a recommendation for an educational consultation between a Child Neurology Clinic educational specialist and the child's school teacher for the purpose of developing a more effective learning program for the child, a referral to parent training, and a recommendation for counseling or therapy.

Thus, the Child Neurology Clinic provides an important comprehensive diagnostic service. It is a highly unique service to the area which, combined with effective consultation and direct services to children and families, provides an effective system of service delivery.

Table 1 represents a log of the children seen by the diagnostic team for the funding period 7/1/78-6/30/79. As indicated, 244 children received diagnostic services during this period. The figure of 244 children seen during the project year represents a net decrease of 43 children over the previous project year. The mean age of children seen this year was 6.3 years. During the previous year the mean was 7.3 years whereas, the year before was 8.6 years. During the second project year the mean number of assessment procedures performed per child was 2.7 whereas during the 3rd project year this increased to 3.2 per child. Thus, the Child Neurology Clinic is serving fewer children, but we are providing more assessment services per child than we had previously.

TABLE I

Summary of Diagnosis and Evaluation Data

Number of children receiving diagnostic and evaluation services (medical, psychological, educational, etc.) during the project year	244
Mean age of children seen for diagnostic and evaluation services	6.3
Number of preschool age children receiving diagnostic and evaluation services (ages 0-5 yrs.)	103
Number of school age children receiving diagnostic and evaluation services (ages 6-21 yrs.)	140
Total number of diagnostic procedures performed for all children seen during project year	787
Mean number of diagnostic evaluation procedures performed for all children seen during project year	$\bar{X}$=3.2

For the purposes of this report data presented is divided into two separate age groups, i.e., ages 0-5 years and ages 6-21 years. These two age groups roughly correspond to preschool age children and to school age children. Review of the following diagnostic and evaluation data suggests this to be worthwhile differentiation (ref. Tables 2-13). There are significant differences across each area, referral source, assessment procedures, and diagnostic recommendations, with the primary differences being a predominance of development and physical therapy concerns for the preschool children and a predominance of educational and psychological concerns for school age children (ref. Tables 6-13).

The majority of children referred to the Child Neurology Clinic are referred by physicians (ref. Table 2). Total physician referrals accounted for 63% of all referrals to the Clinic during the project year. Of these referrals, the majority were from Dr. James R. Schimschock, Neurologist and Medical Director for the Child Neurology Clinic. These referrals accounted for 49% of all referrals.

TABLE 2

Number of Children Referred

	Ages 0-5	Ages 6-21	Ages 0-21 (Total)
Dr. Schimschock	N=103	N=61	N-119
Other Physicians	N=58	N=22	N=33
Agency (Public/Private)	N=22	N=21	N=43
School	N=4	N=21	N=25
Other	N=8	N=15	N=23
Total	N=103	N=140	N=243

TABLE 3

Percent of Referrals by Source

	Percent of Referrals (0-21 yrs)
Dr. Schimschock	49%
Other Physicians	33%
Agency (Public or Private)	18%
School	10%
Other	9%
Total	100%

Referrals from Dr. Schimschock and other neurologists typically do not require additional neurological testing as these evaluations would already have been performed prior to referral. Therefore, neurological evaluations performed following a referral for services would occur only for those children referred from sources other than neurologists.

It is of interest to note that during the first project year 75% of all referrals were from the medical community while during the second and third project years 63% of all referrals were from physicians. However, this change does not represent a decrease of interest from the medical community. Rather, it reflects an increase in referrals from other sources. More specifically,

during the first project year referral rates from agencies and schools were 8% and 7% respectively. During the second project year, the referral rates rose to 14.3% from agencies and 11.8% from schools. This represents a net increase in referrals of 12.5% from schools and agencies during the second project year. During the third project year referrals from these sources were 18% and 10% respectively. This has major implications for the Child Neurology Clinic as it represents a continued interest in our services from the community at large and is indicative of a growing need for comprehensive diagnostic services for children in the community.

As mentioned previously, a team of professionals is employed by the Child Neurology Clinic to perform comprehensive diagnostic evaluations in response to a set of referral concerns. When enough data has been compiled to present a well defined assessment need, the case is presented to the intake team to determine appropriate diagnostic and evaluation services. To a great extent it is the set of referral questions which will determine the types of testing to be performed.

As shown (Tables 4 & 5), the majority of both preschool aged and school aged children are referred by physicians. The next most common referral sources are agencies and schools. These referrals in combination accounted for 91% of all referrals during the third project year. Thus, the Child Neurology Clinic has been regarded as a viable resource by the medical, educational, and professional community at large. During the project year, the Clinic performed a total of 787 separate assessment procedures with an average of 32 assessment procedures per child (refer to Tables 6 and 7). This represents a net increase of 3 assessment procedures over the previous year and a total of 58 over the first project year. Thus, although fewer children were seen during the third project year than in the second project year, those children seen by the Clinic for diagnostic purposes during the third year received more services than those children seen during the previous two project years.

TABLE 4

Percent of Referrals by Source; Ages 0-5 yrs

	Percent of Age Group	Percent of All Children
Dr. Schimschock	56%	23%
Other Physicians	11%	4%
Agency (Public or Private)	21%	9%
School	4%	2%
Other	8%	4%
Total	100%	42%

TABLE 5

Percent of Referrals by Source; Ages 6-21

	Percent of Age Group	Percent of All Children
Dr. Schimschock	43%	25%
Other Physicians	16%	9%
Agency (Public or Private)	15%	9%
School	15%	9%
Other	11%	6%
Total	100%	58%

TABLE 6

Number of Assessment Procedures Performed

	Ages 0-5	Ages 6-21	Ages 0-21 (Total)
Neurological	N=0	N=9	N=9
Psychological	N=13	N=139	N=152
Educational	N=2	N=131	N=133
Developmental	N=92	N=7	N=99
Occupational Therapy	N=7	N=10	N=17
Physical Therapy	N=91	N=13	N=104
Diagnostic Interview	N=82	N=140	N=226
Speech and Language	N=25	N=15	N=41
Other	N=3	N=3	N=6
Total	N=315	N=467	N=787

TABLE 7

Percent of Assessment Procedures Performed by Area

	Percent of Evaluations Performed by Area	Percent of Children Receiving Evaluations by Area
Neurological	1%	4%
Psychological	19%	63%
Educational	17%	55%
Developmental	13%	41%
Occupational Therapy	2%	7%
Physical Therapy	13%	43%
Diagnostic Interview	29%	93%
Speech & Language	5%	17%
Other	1%	3%
Total	100%	Mean number of evaluations per child, $\bar{X}$=3.2

There is a reflection of the differences in the child's age in the types of assessment procedures performed. Certain procedures were performed often for older children but rarely for the younger children and vice versa. More specifically, psychological and educational assessments were performed for 99% and 94% of school age children respectively. Whereas only 13% of the preschool age children received psychological assessments and only 2% received educational assessments. With respect to developmental and physical therapy evaluations, however, 88% of the preschool age children received physical therapy assessments and 89% received developmental assessments. Conversely, only 5% of the school age children received developmental assessments and only 9% received physical therapy assessments.

Thus, a child's age may be instrumental in determining which assessment procedures are to be performed. Further, the results of the assessments have different implications for a toddler than for an adolescent. For the younger child developmental concerns are foremost whereas for the older child educational concerns are foremost.

Following the assessments, the professionals who evaluated the child discuss their findings and develop a workable treatment plan. The results of this meeting are then shared with the parents during the parent conference. Specifically, the parents are presented with relevant diagnostic information and a set of recommendations and referrals pertaining to the treatment goals. This information is discussed with the parents and the treatment goals are revised as necessary. Typically, a written form is provided listing specific diagnostic recommendations and specific referrals for supplementary services. Providing the diagnostic and referral information to the parents in both written and verbal form serves to facilitate the transfer of information and enhances follow through with recommendations.

The Child Neurology Clinic offers many services to families directly through the Clinic. These services include parent training, educational consultations, developmental classrooms, physical therapy, occupational therapy, and infant stimulation. These service areas account for the majority referrals and recommendations made by the treatment team following a diagnostic workup. Following the parent conference many clients are encouraged to participate in these Clinic services. Thus, the Clinic provides a continuity of services for many of our clients from diagnosis through treatment.

In providing diagnostic and referral services there is an implied treatment as well. In order to determine the extent to which clients actually follow through with treatment recommendations the Clinic has developed and received NINCDS funding to conduct a research project which will assess the rate of client follow through with these recommendations and how we might impact favorably upon the rate of follow through. More specifically, this study attemps to assess the effectiveness of different referral and follow-up methods on referral outcome.

The clients included in the study are randomly assigned to one of five groups. The first group will serve as a contrast group and will receive recommendations and referrals from the diagnostic treatment team in the usual manner. The clients in this group remain naive of any follow-up. After a three month period these clients are unexpectedly contacted in order to assess the extent to which they followed through with the recommendations of the treatment team.

The second group is identical to the contrast group with the exception that these clients are informed during the parent conference that they are to be contacted in three months to determine the extent to which the clients followed through with the treatment team recommendations.

The third group is treated similarly to the second group but with the addition of a contingency contract. This contract specifies the treatment team recommendations and requires a written and verbal agreement between the treatment team and the parents defining what is to be accomplished and how this is to be done.

The fourth group is identical to the second group with the addition of a financial rebate. This condition will assess the extent to which an inducement in the form of a small financial rebate will effect the referral contact rate.

The fifth group is identical to the third group with the addition of the financial rebate written into the contract.

The results of this study will provide valuable information concerning the impact of the Child Neurology Clinic's diagnostic and referral services upon our clients. This information will also be of value in regard to the referral process following and the diagnostic treatment team meeting. A variety of referral techniques may be useful to the treatment team as a means of increasing referral contact rates.

SECTION 1

APPENDIX A

[redacted]
PORTLAND, OREGON 97210

NEUROLOGICAL CONSULTATION

_____ Date [redacted]

NAME [redacted]

ADDRESS [redacted]

TELEPHONE NUMBER [redacted]

DATE OF BIRTH [redacted]

REFERRING PHYSICIAN
OR AGENCY _____

PARENTS [redacted]

[redacted] is a [redacted] year old boy who was referred to the Child Neurology Clinic for evaluation of the boy's seizures. He has been under the care of [redacted] He apparently had what the mother refers to as seizures at birth. During these episodes, he would throw his hands up into a flexed and posture position with his fists tightly clenched, exhibit opisthotic posturing and gasping for a few seconds. Following this, the patient would relax and be totally back to his original state. These episodes began again approximately a year ago. The boy will either be standing or sitting and he will throw his hands into a flexion posture with tightly clenched fists. He becomes starry eyed and will not breath. These last momentarily and are still associated with opisthotic posturing. Following these episodes, the patient will complain that his head hurts.

With the onset of these episodes, approximately nine months ago, the patient's mother took him to his pediatrician. An EEG was subsequently done in March of 1977. The EEG done at Providence Hospital was described as mildly abnormal with a solitary paroxysm of theta activity which is probably related to a seizure disorder. He was subsequently started on Dilantin. He started the liquid Dilantin first but was subsequently changed to the Dilantin pill.

Since the Dilantin was started, the patient has been "better." Better means that the patient is having fewer of the tonic posturing episodes in the upper extremities. His behavior had been more difficult to manage since the onset of these tonic posturing episodes but apparently has improved since he was started on Dilantin.

Currently, he is having three or four of the fist-clenching posturing episodes per day. He takes 50 milligrams of Dilantin b.i.d. plus 25 milligrams at midday. He also has curious episodes when he will suddenly jump out of his chair, round about the room in a very impulsive fashion. His mother notes he has been falling more than usual recently.

III. BACKGROUND INFORMATION

1. Birth weight: _____ [redacted] pounds [redacted] ounces _____ Hospital: _____

Perinatal history: Born following a full term pregnancy and delivery.

2. Illnesses: None

3. Surgery: None

4. Injuries: None

5. Allergies: None known

6. Toxic exposure: None

7. Milestones: The patient walked at about one year. Language development was noted to consist of short three or four word phrases at this time.

8. Immunizations: _____

9. Medications: _____

10. Family history: _____

IV. EXAMINATION:

Height: [redacted] inches Weight [redacted] pounds Blood Pressure 90/60
Pulse 112 regular

Head: OFC 48.5 cm. Ears Clear

Cranial Deformity None Mouth-nose-throat Clear

Bruit None Skin Unremarkable

Neck: Pulses Normal Peripheral pulses Normal

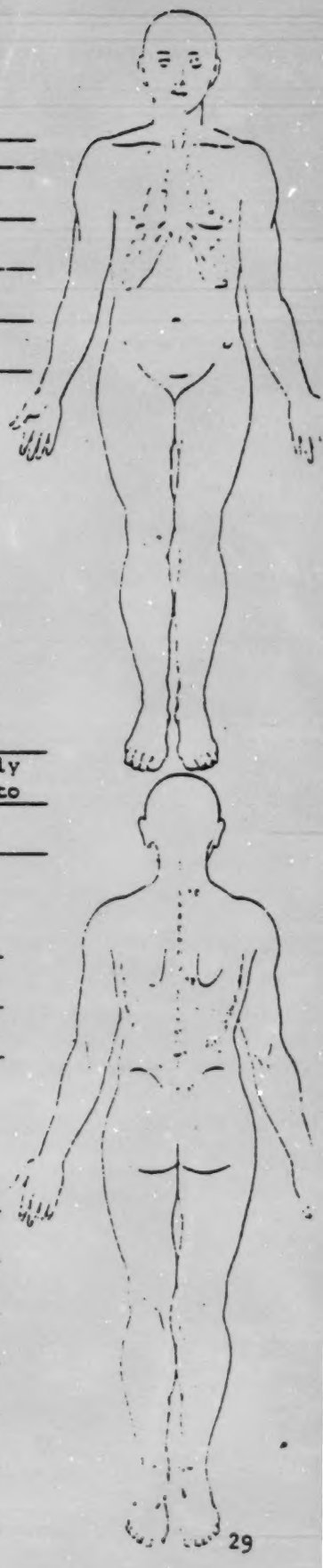
Bruit Genitalia

Chest: Clear

Heart: Not enlarged

Abdomen: Soft

Comments: Wood's lamp examination is unremarkable.



V. NEUROLOGICAL EXAMINATION:

(a) Mental status The patient is a very well behaved, compliant youngster. I did not hear him speaking clearly throughout the examination. He was able to stack blocks and did the block bridge test without difficulty. He shows preference for the right hand and right foot.

Developmental status

(b) Cranial nerves

I. Olfactory Right: Left:

II. Discs: Flat Acuity: OD

Vessels Normal OS

Fields: Full to confrontation

III, IV, VI.

EOM Full range

Pupils 4mm., equal

Nystagmus None

Opticokinetic nystagmus Normal

V. Corneals Right + Left +

VII. Face Symmetrical

VIII. Auditory acuity. Intact

29

IX-X. Palate Midli

XI. Sternocleidomastoid Normal

XII. Tongue/articulation Midline

(c) Motor Examination

1. Musculoskeletal The patient exhibits symmetrical tone and strength.

2. Posture Normal

3. Strength Symmetrical

4. Adventitious movements None

COMMENTS:

(d) Reflexes

1. Muscle stretch reflexes

2. Babinski None

	R	L
Biceps	+	+
Triceps	+	+
Brachioradials	+	+
Abdomenal	+	+
Patellar	+	+
Hamstring	+	+
Ankle	+	+
Jaw Jerk	+	+

(e) Sensory Examination

1. Primary - Pain Light Touch Intact

- Position NO FURTHER TESTING POSSIBLE

- Vibration

2. Cortical - Two point discrimination

- In between

- Localization

- Identification

3. Coordination - Gait Midline gait - no truncal ataxia

- Posture Normal

- Upper extremity coordination Good

- Fine motor coordination Average for age

- Tandem walking

SUMMARY OF PROBLEMS AND FINDINGS

The patient is having curious episodes of flexion posturing in the upper extremities with opisthotonic posturing as well. These apparently appear to be associated with at least an impairment of consciousness. The patient has never had a generalized seizure. These may represent partial complex seizures but the precise etiology of the episodes is not clear.

PLAN

(1) Continue Dilantin 125 milligrams per day.

(2) Hopefully, this youngster will be a candidate for placement in the Child Neurology Clinic program.

(3) We will repeat an EEG with sleep deprivation on the previous evening and sedation if necessary.

(4) The mother will track these episodes on a calendar and keep a written description of the episodes for use of a subsequent visit.

[redacted]

CHILD NEUROLOGY CLINIC
2222 N.W. Lovejoy, Suite 361
Portland OR 97210 (503) 229-7220

[redacted]
Initial Interview

B.D. [redacted]
C.A. [redacted] years
Test Date: [redacted]

Referral Source: [redacted]
Examiner: Albert Greenwood

Reason for Referral: [redacted] was concerned about [redacted] hyperactive and hard to control behavior. He has problems in speaking clearly. He also tends to run into objects according to the mother.

Family: [redacted] were separated six months ago. They have one child, [redacted], who now lives with the mother in Gladstone. Both he and the mother are living with [redacted] mother. [redacted] works full-time as a cosmetician and takes [redacted] to his mother-in-law's daily for babysitting. [redacted] works some evenings and during those days [redacted] grandmother cares for him while [redacted] is away.

[redacted] visits [redacted] one time a week for a couple of hours. According to the mother [redacted] gets along better when men are around and responds more obediently to masculine figures. [redacted] is a man who apparently does a number of things and at the present time works partly as a farm laborer and as a machinist. He was unemployed for a period of one year from 1976 to early 1977. The unemployment lasted for one year between [redacted] first and second birthday. During this time the mother worked six days a week to support the family. The recent separation was not something that happened suddenly. [redacted] was reluctant to discuss the details of the separation although she spent considerable time discussing the struggle she and her husband had about the problems in relocation and finances in a separation.

[redacted] when living at home was the disciplinarian. The main method of discipline was and still is spanking although [redacted] states that she tries to talk and reason with [redacted] too. She commented that sometimes [redacted] needs to be spanked "real hard" because he over-reacts to things. At the present time mother disciplines [redacted] as does [redacted] mother. [redacted] feels that a woman's place is not as good for disciplinary purposes and indicates some loss of control in managing [redacted] behavior.

Developmental: [redacted] has an apparent seizure history dating from about approximately one month old. These early seizures are undocumented but the mother is sure that that is what they were. She states that these seizures occurred until approximately the second month at which time their frequency decreased. Seizure-like behavior increased again towards the end of the second year at which time [redacted] took [redacted] to the doctor and medical management began. [redacted] has been on Dilantin for the last eight months although the mother states that at the

present time no improvement in seizure-like behavior has occurred.

[redacted] describes her son's seizures as a period where he "acts like a goon". His hands with clenched fists or raised at head level and some facial contortions are evident. The frequency of such behaviors is variable. [redacted] states that he may have one very five minutes to one or two a day. The duration of the seizure-like behavior is variable and may range from a very brief momentary appearance upwards to one minute. The seizure-like behavior may occur in a variety of situations. Most often it is before or after a nap although [redacted] also states that the behavior may occur at any time during the day and has occurred up to four times during the night. Following the seizure-like behavior [redacted] states that [redacted] is irritable and also inactive. The mother often asks if he is allright at which time he responds he is fine. The mother states it is like he is daydreaming for a short period of time after the seizure-like behavior. His face will turn red at times during such behavior and [redacted] states that this is the most critical sign that convinced her that her son was having seizures.

[redacted] has always been an active child. He is inattentive child and often disobeys his mother's commands. His behavior improves dramatically when he is rested, and the mother tries to nap him once a day. There is no particular time when [redacted] takes a nap and mother states it is hard to be consistent with him because he acts differently every day, "just like a hyperactive child would". The mother qualified some of his inattentive and disobedient behavior by acknowledging that her son is not well and refers to him as "being sick".

There is a history of balance problems which dates in [redacted] recollection from the time he began medications. She sees balance problems increasing when medication increases and decreasing proportionately. She states that she must hold [redacted] hand as he is going up and down stairs or he will fall over. During the interview [redacted] stumbled into this examiner's chair while walking around the room and also hit his head on a desk while attempting to reach a block underneath it. Before he began treatment with Dilantin [redacted] felt that he was "slower" although she remembers no significant difficulty in walking. [redacted] could not remember the period of time when [redacted] began to walk although she states it was over a year and around 14 months. [redacted] spoke his first words around his second birthday. Potty training is now underway but is difficult due to the erratic behavior pattern that occurs daily. [redacted] speech is garbled and ranges from very poor articulation to clear pronunciation of single words.

[redacted] has many questions about the behaviors that [redacted] is exhibiting and the response he has had to medical treatment. She wants to know "if all this is normal". She is also extremely concerned about the issue of behavior management, management which seems at this time to be out of control.

Summary: [redacted] presents a child, [redacted], who has a long history of seizure-like behavior although until recently this was not documented. [redacted] has been receiving pharmacological treatment for his seizures for

the past eight months with Dilantin. The mother's major concern at this point is that there seems to be no way to control [redacted] erratic and hyperactive-type behavior. Presently [redacted] has difficulty in discriminating between her difficulty in managing [redacted] behavior, and the confusion and concern she has about his seizure-like behavior. Behavioral management is certainly a major issue and there appear to be many questions concerning seizure behavior and child rearing that [redacted] is unsure of and would like answered at this time.

Albert Greenwood
Examiner

AG/mm

CHILD NEUROLOGY CLINIC
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[redacted]
Developmental Evaluation

B.D. 2/21/75
C.A. 2.8 years

Referral Source: [redacted]
Examiner: Susan Holstrom
Date of Evaluation: [redacted]

Instruments Employed: Boyd Developmental Progress Scale
Minnesota Child Development Inventory

Reason for Referral: [redacted] was referred to the Child Neurology Clinic because of concerns in the area of expressive language, perceptual problems when walking, behavior problems, and uncontrolled seizures. [redacted] described [redacted] as hyperactive and difficult to control.

Contact with Parents: [redacted] accompanied [redacted] to the Clinic and remained in the room with him throughout the evaluation. She appeared uncomfortable during the evaluation especially when [redacted] answered incorrectly or refused to perform. She commented that it often took a good spanking for [redacted] to begin behaving when he acted as he did during the evaluation.

Observations: The evaluation took place in the preschool classroom and lasted approximately 20 minutes. [redacted] initially complied with commands to sit down and performed several fine motor activities. As testing proceeded the compliance decreased. [redacted] refused to leave his chair and attempt gross motor activities. He was not very responsive to social and tangible reinforcement. He did not appear to understand "if - then" sequences of behavior. Several times during the evaluation [redacted] indicated a very strong interest in certain objects but would not attempt requested tasks in order to play with these objects. Instead he used fussing and persistent attempts to reach an object that he wanted. In only one instance did [redacted] give a requested response (verbalization of the word "clock") in order to obtain a desired object. Many items [redacted] refused to perform saying "no" or physically retreating. Some of these items were subsequently scored by observations of his free movement about the classroom.

Results of Evaluation:

Motor: Approximate Developmental Level: 2.6 years: In the 18-24 month age range, [redacted] built a tower of four blocks, imitated a vertical line, and jumped (not on request). [redacted] was observed throwing a ball overhand though he refused to do so on request. [redacted] reports that she assists [redacted] in walking upstairs. In the 2-3 year range [redacted] built a bridge of three blocks on the second attempt and cuts one snip with scissors. [redacted] was observed to balance on one foot for one second though he refused to do this on command during the evaluation. [redacted] describes [redacted] trike riding skills as at a beginning level and

not yet independent. [redacted] did not pass the criteria for copying a circle but did draw continuous circular patterns in response to the model of the circle. [redacted] demonstrated a well developed pincer grasp and was slightly above the three to four year time limit (30 seconds) for placing pellets in a bottle. [redacted] appeared to be functioning near age level in the gross and fine motor areas.

Language: Approximate Developmental Level: 21 months: [redacted] passed no items above the two year level in this area. In the 18 month to 2 year range he pointed to only one body part (nose). In response to my request to point to other body parts, [redacted] made unintelligible verbalizations and pointed to toys and objects in view. He did not appear to understand what was being asked of him. He followed only one command regarding positions (put the block on the table). When I added a gesture of an open hand to the command "give the block to me", [redacted] immediately complied. Without the gesture he merely set the block on the table. The mother reports that he is inconsistent at home in bringing objects to her upon request. She indicated that his performance depended on his daily moods. She describes his play with other children as mainly imitative and parallel. [redacted] spoke in one to four word phrases but in the longer phrases most of the words were unintelligible.

Self-Sufficiency: Approximate Developmental Level: 2 years: In this area also [redacted] did not pass any items above the two year level. In the eighteen month to two year range, [redacted] describes [redacted] as able to discriminate edibles, to unwrap candy or gum, and put on several articles of clothing. He can play independently in a room separate from the mother for only five to ten minutes "if he is quiet". Certain doors and cupboards are locked at home for his safety. In the two to three year range [redacted] is inconsistent in his skills involving the use of a fork and washing and drying his hands. The mother reports that she gets a drink for him when he is thirsty because she doesn't trust him to get a drink independently. She is especially concerned about his lack of recognition of danger in regard to streets. She reports that he will dart out into the street and thus he is very closely supervised.

Parent Reporting: [redacted] perception of [redacted] skills is that he is performing at age level or above in all areas of development. With this parent reporting instrument employed scores above age level cannot reliably be interpreted as signs of accelerated development. [redacted] had difficulty describing [redacted] skills when speaking with the examiner and at times questioned my scoring of his responses during the evaluation. For example, when [redacted] did not count two objects, she remarked that he does this all the time at home. However, she models the counting first for him.

Summary: [redacted] appears to be functioning close to age level in the motor area but well below in the language and self-sufficiency areas. He was noncompliant and inconsistent in responses during the evaluation. [redacted] refusals occurred in response to requests and modeling by both the examiner and his mother. He does not seem to have learned "if-then" sequences of behavior and appeared bewildered by much of what was requested of him during the evaluation. Perceptual problems when walking (running into objects) were not observed. I would not describe [redacted] behavior

as hyperactive. He sat and attended for ten to fifteen minutes. It was difficult to get him to perform certain tasks even using tangible and social reinforcement. Language skills, not only the lack of intelligibility of many words but also the lack of receptive concepts, were of special concern to the examiner. Since [redacted] responded inconsistently in this area and better with added gestures, I feel the possibility of a hearing loss should be investigated. The desparity between the mother's perception of [redacted] skill level and the evaluator's observations of [redacted] performance is another area of concern. I feel the mother will need training to observe [redacted] more closely and objectively in order to help change his behaviors.

Recommendations:

1. Hearing evaluation at the Infant Hearing Resource Center.

2. Placement in the Child Neurology Clinic classroom setting five days a week.

3. Parent training at the Child Neurology Clinic for behavior management and skill development in conjunction with the classroom placement.

4. A neurological evaluation by Dr. J.R. Schimschock to determine the presence or absence of seizures and to effectively control them if present.

Susan Holstrom

Susan Holstrom, M.S., Sp.Ed.
Education Coordinator

SH/gw

CHILD NEUROLOGY CLINIC
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[redacted]

Physical Therapy Evaluation

B.D. 2/21/75
C.A. 32 months

Referral Source: [redacted]
Examiner: Helen W. Jones, L.P.T.
Date of Evaluation: [redacted]

Instrument Employed: CCD Scale of Developmental Motor Progression

Reason for Referral: This [redacted] month old child was seen for evaluation of motor development per request Dr. Wallicher. [redacted] presented as a somewhat fatigued child, not fully willing to cooperate but amendable to coaxing.

Using the CCD Scale of Developmental Motor Progression as a guide, [redacted] passed items to age level except in the areas of stair climbing, and balance beam use, due to inability to test. By report [redacted] uses one handrail ascending stairs with a reciprocal gait, and uses one handrail with both feet on the same step descending stairs, which would be to age level.

Orthopedically, nothing abnormal was demonstrated. No tone abnormalities were observed, and balance and protective reactions were present and reliable.

In summary, [redacted] is functioning within normal limits regarding gross motor development. No physical therapy is indicated.

Helen W. Jones L.P.T.
Helen W. Jones, L.P.T.

HWJ/mm

SAMPLE B

[redacted]
PORTLAND, OREGON 97210

NEUROLOGICAL CONSULTATION

_____ Date [redacted]

NAME [redacted] REFERRING PHYSICIAN OR AGENCY [redacted]

ADDRESS [redacted]

TELEPHONE NUMBER [redacted] PARENTS [redacted]

DATE OF BIRTH [redacted]

[redacted] is a [redacted] month old younster who was referred here for an evaluation of his motor development. This child was born by C-section following a full term pregnancy. At birth, the younster was observed to be having some respiratory difficulty. He had one dusky episode and was tachypneic.
He was exhibiting marked sternal retraction and had a rather peculiar cry. Subsequently, chest films were done and the youngster was started on antibiotics because of borderline bronchial changes. The problem gradually resolved. The patient was subsequently subjected to contrast studies to rule out the possibility of T.W.fistula. These were done at the Medical School, under the direction of [redacted]
Initially, it was thought that the boy may have trachial malacia secondary to a defect in cartilage formation or epiplasia of the pharyngeal structures.

As the boy developed, he was a somewhat ungrown youngster. He was breast fed and had some difficulty feeding. His mother describes him as being a somewhat floppy youngster who would become extremely aggitated if he was suddenly picked up and/or startled.

At age [redacted] months, the boy is described as being "not very strong". His mother reports that his muscle tone has increased. However, he is not able to roll over and does not sit with assistance, or if placed in a sitting position. He will make some swimming type crawling movements. He is putting objects in his mouth but is somewhat limited in his motor ability.

The boy has had no seizures. His motor developement is improving but very slowly.

III. BACKGROUND INFORMATION

1. Birth weight: [redacted] oz Hospital

Perinatal history: see present illness

2. Illnesses: none other than perinatal

3. Surgery: none

4. Injuries: none

5. Allergies: none

6. Toxic exposure: none

7. Milestones: The patient is putting objects into his mouth and will reach for some objects but will not roll over and does not sit without support.

8. Immunizations: up to date

9. Medications: none

10. Family history: The patient is one of three siblings. The first child died of crib death at age 4 months. The boy's three year old brother, [redacted], is having some behavioral-developmental problems, please refer to his workup.

IV. EXAMINATION:

Height _____ Weight [redacted] # Blood Pressure 80/50
Pulse 110 reg

Head: OFC 44.2 cm Ears clear

Cranial Deformity none Mouth–nose–throat clear
transillumination negative

Bruit _____ Skin normal

Neck: Pulses normal Peripheral pulses normal

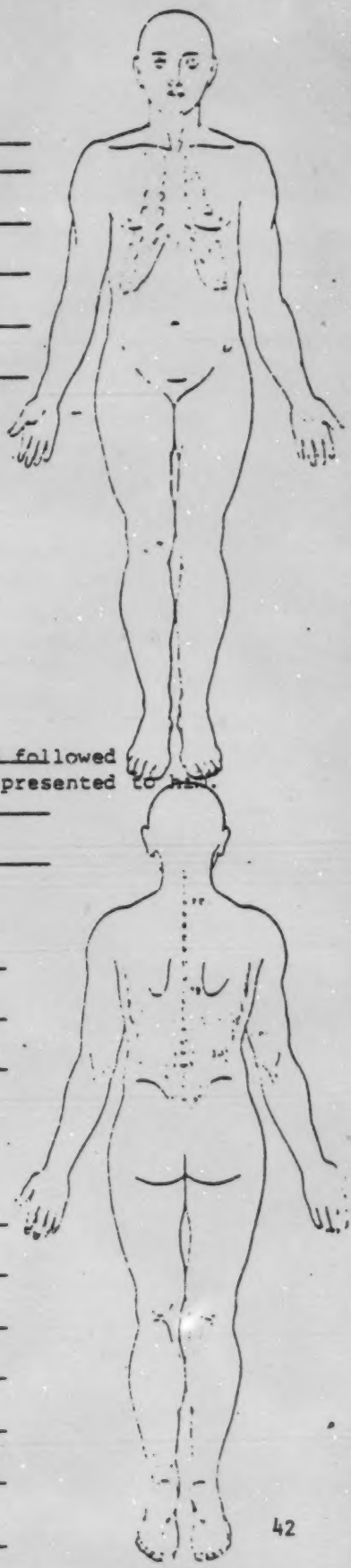
Bruit _____ Genitalia _____

Chest: clear

Heart: not enlarged

Abdomen: soft

Comments:



V. NEUROLOGICAL EXAMINATION:

(a) Mental status very alert, interested. Good eye contact and followed extremely well. He will not reach for objects presented to him.
Developmental status He has a crude palmar grasping

(b) Cranial nerves

I. Olfactory Right: _____ Left: _____

II. Discs: retinas normal Acuity: OD _____
discs flat
Vessels normal OS _____

Fields: grossly full to confrontation

III, IV, VI.

EOM full range

Pupils 4mm, both react to light

Nystagmus, none

Opticokinetic nystagmus normal

V. Corneals Right + Left +

VII. Face symmetrical

VIII. Auditory acuity: Intact

IX-X. Palate midline

XI. Sternocleidomastoid normal

XII. Tongue/articulation midline, no dysarthria

(c) Motor Examination

1. Musculoskeletal generally decreased motor tone. He is somewhat floppy and exhibits borderline head control. The tongue is of normal size. There are no fasciculati
2. Posture The muscle mass is definitely decreased. The boys hands and feet seem proportionately large compared to the bulk of his proximal and
3. Strength distal extremities.
4. Adventitious movements

COMMENTS:

(d) Reflexes

1. Muscle stretch reflexes 2 + bilaterally.
2. Babinski none consistently demonstrated.

	R	L
Biceps		
Triceps		
Brachioradials		
Abdomenal		
Patellar		
Hamstring		
Ankle		
Jaw Jerk		

(e) Sensory Examination

1. Primary - Pain Light Touch intact
   - Position
   - Vibration
2. Cortical - Two point discrimination
   - In between
   - Localization
   - Identification
3. Coordination - Gait
   - Posture poor head control
   - Upper extremity coordination does not reach or grab for objects, parachute reaction not present.
   - Fine motor coordination
   - Tandem walking

SUMMARY OF PROBLEMS AND FINDINGS

This youngster presents a history of respiratory difficulties and slow motor development. I cannot pin point any specific congenital myopathy and I suspect that we are dealing with central hypotonia. I would like to watch this youngster's developmental progress. In talking to the parents, I would like to send the boy to the Child Neurology Clinic. After talking to the parents, we decided to do it now rather than wait.

PLAN

CHILD NEUROLOGY CLINIC
2222 N.W. Lovejoy, Suite 361
Portland OR 97210 (503) 229-7220

[redacted]
Initial Interview

Toby: B.D. [redacted]
C.A. [redacted] years

Date of Interview: [redacted]

Reason for Referral: [redacted] were referred to the Child Neurology Clinic by Dr. Schimschock who saw both of them in a neurological consultation in June 1977. Dr. Schimschock suggested that both children be seen at the Child Neurology Clinic for a developmental evaluation. On 7/18/77 [redacted] brought [redacted] to the Clinic and a Baylay was performed as well as a Boyd Developmental. At this time I was able to speak briefly with [redacted] and to administer a developmental profile on [redacted] who was not present.

Neurological: (For a full neurological report see Dr. Schimschock's consultation date 6/10/77.) Generally no overt neurological abnormalities were found in Toby's evaluation and Dr. Schimschock felt that Toby's hand shaking was not of neurological significance. This hand shaking seems to occur most often when Toby anticipates a pleasurable event or is observing some event he finds interesting.

Present Situation: [redacted] and his brother [redacted] age [redacted] months live with their parents [redacted] and [redacted] in [redacted] is a welder with Marine Iron Works and [redacted] is employed as a bank teller. [redacted] is presently attending the Providence Montessori School summer session which she describes as basically a daycare setting with little programming. It is her understanding that when the regular Montessori school starts in the Fall that there will be specialized activities for [redacted] to engage in. [redacted] reported that [redacted] is a very active child and, in her estimation, a bright child with a good memory but one who often refuses to comply and seems to be functioning at a level lower than a similar aged cousin. She reported that when [redacted] becomes tired from over-exertion he typically also becomes very active and hard to control and his high level of activity often gets in the way of his being able to perform tasks. [redacted] noted a number of areas of non-compliance, including putting on clothes and eating with the proper utensils. She stated that she typically does not press [redacted] to perform correctly in these areas and that he could, for instance, dress himself to a greater degree if she did not assist him in doing so. [redacted] will typically eat with his hands but can use a spoon and fork correctly if told to do so. When compliance and behavioral issues were addressed in greater depth [redacted] said that these were not the areas of greatest concern, that she would rather address [redacted] developmental difficulties first and wait to see how [redacted] functioned in the Montessori school.

Developmental Profile: I administered the Alpern/Boll Developmental Profile to [redacted] This is a parent reporting profile of a child's activities in the physical, self-help, social, academic, and communication areas and was used as a gross screening devise to determine [redacted] general level of functioning. In the physical area [redacted] was reported as having difficulties in gross motor activities such as leaping with feet together, jumping, and hopping. [redacted] does not peddle a tricycle but instead will wait for someone to push him. Some difficulties were also noted in fine motor skills such as copying a straight line. His overall score in

the physical scale was 2.4 years. [redacted] reported abilities in self-help activities are slightly lower; in this area he achieved a score of 2.2 years. Specifically [redacted] does not involve himself in any dressing or undressing activities independently but instead waits for his mother to take care of these needs for him. While he apparently is able to use a fork and a spoon appropriately he prefers to eat with his hands and this is not usually consequated by either parent. In the social development area [redacted] received a score of 2.10 years which is within the normal range for his age group. His mother reports that until a very short time ago he would call everyone [redacted] and has only recently begun addressing her as "mom". While he does not yet seem to understand rules about taking turns in group play his mother reports that he does understand ownership of items and will not take things that belong to others. [redacted] showed some delay in the academic scale, scoring at 2.4 years in this area. His mother is not sure whether he recognizes himself in a photograph (a 2 year skill) but does report that he does not seem to take any interest in his picture over any other. He does, however, seem to recognize his father's picture. [redacted] does not group objects together by color or form, does not consistently use any size words, does not seem to differentiate between colors when asked, and does not understand the concept of "three" well enough to hand over three items when asked, although he reportedly can count up to 16 by rote. [redacted] reported performance in the communication area was approximately 2.8 years. This is a low score but is also generally within the normal range for a child his age. He passed all items up to 2½ years but does not give either his first or last name when asked and generally does not answer any questions which are presented to him.

Overall [redacted] performance on the Developmental Profile as reported by his mother showed a delay in the five areas between six months and one year. These results are confounded by several factors. First of all, [redacted] freely reported that there are many areas in which she did not press [redacted] to perform, areas in which she herself takes responsibility for actions that [redacted] is capable of such as dressing. It is uncertain from just the Developmental Profile report whether the delay is actually present or whether [redacted] has merely been taught well to allow others to do for him. Additionally [redacted] seemed rather reluctant to discuss [redacted] behavioral difficulties in any great depth, saying that she would prefer to focus in on the developmental delays suspected with her other son [redacted] at the present time. Dr. Schimschock finds no overt neurological difficulties to explain [redacted] hand flapping under stressful or exciting circumstances and I think the best way to address this problem would be to have [redacted] enter the Child Neurology Clinic classroom on a short term, observational basis giving time for more indepth developmental testing. In the absence of direct observation and a developmentally oriented examination of [redacted] himself I am uncertain how much of his difficulties are learned behavior, how much are the result of tension or anxiety as postulated by Dr. Schimschock and how much may be the result of an actual developmental delay.

[redacted] will get in touch with us after checking with the bank management where she works and let us know of a time that is best for her to hold a parent conference. I will address these questions with her at that time.

[redacted]
Staff Social Worker

BMD/mm

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[redacted]
Developmental Evaluation

B.D. [redacted]
C.A. [redacted]
Referral Source: Dr. James Schimschock
Examiner: Nancy Troth
Test Date: [redacted]

Instruments Employed: Denver Developmental Screening Test

Reason for Referral: [redacted] was referred to the Child Neurology Clinic by Dr. James Schimschock for developmental testing. [redacted]'s main question is whether [redacted] will ever "catch up". The skills she would like to see [redacted] acquire immediately are sitting up, rolling over and grasping objects.

Contact with Parents: This examiner had only a brief encounter with [redacted] as the main testing was done by Bruce Boyd. However, it was this examiner's impression that [redacted] seemed "angry". This was demonstrated in the way she asked how the testing was going to help [redacted] She also appeared defensive at one point when she stated "he isn't usually so fussy" (he whined for a good part of the test). The examiner noted that [redacted] seemed to be burping and straining and casually suggested that perhaps he had some gas and that this was the reason for his fussiness. Apparently [redacted] misunderstood and snapped back saying "that is the way he breathes". The examiner repeated what she said and [redacted] made no comment.

Fine Motor-Adaptive: [redacted] was able to grasp a rattle, reach for an object and follow an object 180 degrees. He did not appear to attempt to pick up a small pellet, he didn't look for an object when it was dropped and he did take two cubes placed in front of him. [redacted] reported that she couldn't remember seeing [redacted] pick up two items.

Language: [redacted] laughed, said "dada" and [redacted] stated that he imitates speech sounds.

Gross Motor: [redacted] was able to lift his head and chest up so that his face made a 90 degree angle with the table. He also held his head steady when held in a sitting position. He didn't lay on his stomach with his forearms outstretched for support. This examiner did not observe [redacted] to roll over. [redacted] said he does roll over but not often. [redacted] did not bear weight on his legs. He bent forward and his legs were straight but not such that he was bearing any weight. He was unable to sit without support and there appeared to be a slight headlag.

Personal-Social: In the personal social sector, [redacted] resisted when a toy was pulled from him, worked for a toy out of reach and smiled spontaneously. [redacted] said he does not do any finger feeding.

Summary: Results of this evaluation would seem to indicate that [redacted] is functioning abnormally for a child his age. He showed one delay in the personal social sector; this being that he is unable to feed himself a cracker. In the fine motor-adaptive sector, [redacted] demonstrated three delays; he didn't look for an object when it was

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dropped, he did not attempt to rack a pellet and he did not take two cubes placed in front of him. In the gross motor sector, [redacted] appeared delayed on four items, specifically, bearing some weight on his legs, pulling to sitting with no head lag, sitting without support and holding his chest up by support, supporting himself on his hands. [redacted] appears to be functioning on target in language at this time.

Recommendations:

Because [redacted] appears to be quite delayed in the motor area, it would seem appropriate to have him evaluated further by a physical therapist. Intervention either in the form of a home program or inclusion in the Child Neurology Clinic's infant class, would seem very important in order to facilitate appropriate programming for [redacted].

Nancy Troth (RD)
Nancy Troth,
Teacher - Toddler Program

NT/gw

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[redacted]
Developmental Evaluation
Date of Test: [redacted]

B.D. [redacted]
C.A. [redacted]

Referral Source: James R. Schimschock, M.D.
Examiner: Bruce Bloyd, Psychometrist; R.D.Charlton, Ph.D.

Instruments Employed: Bayley Scales of Infant Development

Reason for Referral: [redacted], an [redacted] month old infant, was referred to the Child Neurology Clinic by James R. Schimschock, M.D. because of concerns about his motor development. Dr. Schimschock's observations suggest the possibility of some developmental delay. He is not able to roll over or sit unassisted. Dr. Schimschock's neurological suggested the possibility of central hypotonia. The Bayley's Scales of Infant Development were administered in conjunction with other developmental instruments.

Observations: [redacted] had just eaten prior to the evaluation, and it was reported by the baby sitter who came with the mother to the evaluation, that he is often active for a period of twenty minutes following eating. Observations during the evaluation suggested that he was alert and active. At times he was fussy but usually attentive. Through the first few minutes of the evaluation he had the fingers of his right hand in his mouth. It was often difficult to capture his attention more than briefly. He did however smile and laugh when he was stimulated by his mother. Sound seems more useful than visual stimuli in gaining his attention. When not attending to stimuli, he made random arm movements and appeared active and alert. The overall picture suggests that the child was responsive to the evaluation and was in fact neither tired and/or moody. Thus, it is felt that the scores obtained on this evaluation are an accurate reflection of his current abilities. The mother, who observed the evaluation, agreed that his performance was fairly typical.

Results of Developmental Evaluation: The results obtained from the Bayley Scales of Infant Development suggest that [redacted] is exhibiting abilities at approximately the 5⅓ month level on both the mental and motor indices of the instrument. While motor problems may account for some failures on the mental index, it is unlikely that the two indices would be so consistent if there were not a delay in both. Failures on the mental scale seem to be on tasks requiring some eye/hand coordination.

Thus [redacted] is a [redacted] month old infant showing a general 3⅓ month delay in development. Motor problems are most apparent, however there may also be a significant visual component in this delay. In view of this significant delay, it is recommended that [redacted] have a Physical Therapy consultation which would likely lead to

ongoing PT for this youngster. Placement in an Infant Stimulation program or other ongoing intervention program should be considered. Re-evaluation in approximately 6 to 9 months is also indicated. The last recommendation would be a visual examination.

Richard D.Charlton, Ph.D.
Clinical Psychologist

RDC:sw

SECTION ii

PARENT TRAINING DATA

PARENT TRAINING

During the third project year the parent training program focused its efforts toward three major areas. These areas of activity included:

A. The continuation of the Child Neurology Clinic individual parent training model.

B. The continued development and implementation of alternative approaches to parent training, specifically group parent training and training through the Child Neurology Clinic developmental classrooms.

C. The development of audiovisual materials to supplement the existing parent training models.

There has been considerable success in each of these areas during this project year. The individual parent training model continues to be utilized. The group parent training model has been implemented successfully and training through the developmental classrooms has proven successful as well. A series of four parent training films have been planned, three of which have been completed while the forth is currently being produced. Sample scripts for these videotapes are included (ref. Appendix A).

The parent training program has become an integral component of the service model at the Child Neurology Clinic. Parent training serves as a logical adjunct to the Clinic's developmental classrooms and as a viable resource to families seen for diagnostic and evaluation services through the clinic. The combination of these services provides for a comprehensive service made for families with handicapped children.

The parent training model used at the Child Neurology Clinic relies heavily upon the collection of data. Parents are taught to quantify and to describe in behavioral terms those behaviors exhibited by their children which they desire to change and/or those skills which they desire for their children to acquire. The parents are then taught to collect baseline data against which to assess change in their child's behavior or skill levels. Following the collection of baseline data by the parents, the parent trainer will assist the parents in developing prescriptive behavior management and/or skill acquisition programs for their children. Throughout this process the parents are encouraged to set their own priorities, to specify areas of interventions, and to define program goals (ref. Appendix B).

Families may become involved in parent training through the Clinic in any of the three training models, i.e., group parent training, individual parent training, or parent training through the developmental classrooms. Further, they may change from one model to another. It is not unusual, for example, for a family to become involved in individual parent training following completion of an eight week group parent training session. Nor is it unusual for parents working in the developmental classrooms to also become involved in the group parent training model.

As mentioned, parents define those behaviors and skill levels which are to be impacted upon. Further, parents determine what the terminal objectives for each program will be. These terminal objectives serve as criteria for success for each program implemented. There is, then, a well defined method for measuring change against a baseline level and a specific objective for determining success, which together provide a realistic framework for assessing the effectiveness of the individual intervention programs.

To assess the extent to which successfully terminated programs have maintained, the parent trainer may contact the family three months following the termination of parent training. Parents are asked to collect data one week prior to the actual follow-up meeting to establish a new baseline level for those behaviors and/or skills worked on during parent training. This information is useful in determining what changes are needed in training methods, if any, and in determining whether additional parent training is needed.

Table 1 presents summary data of the parent training program for the project year. As shown, a total of 155 children were impacted upon during the third project year. The figure of 286 parent conducted programs during the second project year represents a significant increase over the figure of 77 during the previous year. During the third project year the total number of parent training programs conducted increased again to 465. This represents an increase of 179 programs during the third project year.

TABLE 1

Parent Training Summary Data

Number of families in parent training during project year	130
Number of children impacted upon during project year	155
Number of families in group parent training	10
Number of families in individual parent training	120
Total number of programs for all children in parent training	465
Mean number of programs for all children in parent training	$\bar{X}$=3

It is of interest to note that the majority of programs conducted are for children ages 0-8 years. It is also of interest that all of the skill programs conducted were for children ages 0-8 years. This is of particular significance as it indicates that the Child Neurology Clinic parent training program has an impact upon children at an early age. Further, there has been a predominance of behavior programs conducted through the parent training program. It is evident, then, that there exists a complimentary relationship between the Clinic parent training program and the Clinic training classrooms with the parent trainers teaching behavior management techniques and the classroom demonstrating skill building techniques.

Parent training in the developmental classrooms is utilized primarily for training those parents whose children have been enrolled in them. These parents are encouraged to volunteer one day per week in the classrooms. They are trained by the classroom teachers and the parent trainers to conduct one-to-one activities with the children, working on skill areas including expressive and receptive language, fine motor skills, and self-sufficiency skill development. The parents first work with children other than their own until they demonstrate sufficient skills to begin to work more independently with their own child.

In the group training model the success rate was comparable to that of parents in individual parent training. This becomes more meaningful when one considers the time factors involved. The group parent training model may have impact on more families per hour of parent trainers' time than the individual training model with similar results and is therefore considerably more cost effective.

The group parent training model consists of an eight week course with weekly meetings. Typically these meetings have occured at night to allow the working parents to participate. There have also been daytime groups, however. The members of each group are presented with a training package during the first training class which contains the class syllabus and guidelines for developing behavior management programs (see Appendix C). The parents involved are all screened as to the similarity of their needs and the nature of their child's behavior problems. Groups have typically been limited to four or five families. As a result, the group of parents are generally able to work together as a group which serves to facilitate the learning process.

As a means of determining the extent to which group trained parents learned the behavior management techniques and terminology a pre-test and post-test are administered (see Appendix D). The criteria for having adequately learned the material presented would be a post-test score of 90%. Based upon data obtained and parental feedback, the child Neurology Clinic group parent training model appears to have been implemented quite successfully during the project. The extent to which the Child Neurology Clinic training models have proven to be effective has major implications for future Clinic parent training efforts. Both the individual and group parent training models will continue to be used at the Child Neurology Clinic. Parent trainers will continue to help parents design and implement intervention programs in skill building and behavior management areas.

SECTION ii

APPENDIX A

Parent Training Video Tape Script

REINFORCEMENT

NARRATION	SCENES
Human behavior is governed largely by its consequences. What we choose to do depends greatly on what we get...or don't get...for doing so.	
We avoid doing things that result in pain...or punishment.	Flash shots of such things as hospital bed, someone burning hand on burner, child getting scolded by parent.
We do those things which reward us pleasurably...with affection, praise, or money.	Eating a nice meal, turning work into the boss, adult hugging child for doing something well (playing together).
The decisions we make about what to do...and not to do...are being made even when we are very young. And parents are central to that process.	Parents interacting with very young child.
As a child's primary source of pain and pleasure, parents have great influence over a child's behavior... whether consciously..or unconsciously.	Show children dressing up in adult clothes, saying adult type things.
Your immediate response to your child's behavior is the single biggest reason for his deciding to repeat it...or eliminate it.	Show parent clapping when child successfully gets pants on.
To be conscious of the ways in which you are influencing your child's behavior is to begin to be able to make the changes you would like to make.	Parent sitting on couch next to child, parent smoking cigarette. Child imitates smoking a pencil, parent sees this and snuffs out cigarette.
We call responses that decrease behavior "punishers"...and responses that increase and strengthen behavior "reinforcers", or rewards.	Words on screen
Reinforcers are some of the most effective tools a parent has in the task of changing negative behavior.	

Food reinforcers are whatever foods your child particularly likes--raisins, nuts, juice, cookies.	Show checkstand at grocery store and/or grocery shelves.
Social reinforcers--praise, attention, smiles, applause, hugs--come from other people. Children learn from their parents to like social reinforcers...and in time usually come to prefer social reinforcers to food reinforcers.	Parent praising child
Tangible reinforcers--toys, trinkets, privileges, TV, trips to the zoo--are all those things that your child especially likes to have and do.	Parent taking children out for a walk.
Tokens are symbolic reinforcers--stars, stickers, money--which can be cashed in on other rewards.	Child gets star on chart on refrigerator.
All of them can be used effectively to increase your child's good behavior.	
If you are unable...or reluctant...to provide extra reinforcers for your child, you might try emphasizing those reinforcers which occur naturally in the home...	
like dessert...for a clean plate...	Family at dinner table.
or getting to help Mom...for playing quietly.	Show parent approaching child at kitchen table.
But be specific.	Scene with Dad and the two children at home for the evening while Mom is out - Dad offers a special treat for "being good".
Special treat at bedtime is a natural reinforcer for the childrens' good behavior...but it may not be clear to the children what their father will accept as "good" behavior.	Repeat of the same scene, only Dad is more specific about what behavior he wants.
Now the expectations are clear.	

How you deliver your reinforcement can make an enormous difference in how your child responds to it.	
Weak reinforcement gets weak results.	Parent delivering weak reinforcer.
Be sincere and enthusiastic in your praise.	Same scene, stronger reinforcer.
A delayed reinforcer...is a weak reinforcer.	Parent teaching a dressing task to child, child accomplishes task, parent runs to turn off stove, then comes back and reinforces child.
Reinforce a child immediately when you can...	Same scene, only immediate reinforcer.
and when a delay is unavoidable, describe the behavior to your child... and then reinforce it.	Parent describing child's behavior at Grandma's house, then reinforcing child.
Catch your child being good. Don't wait for him/her to request reinforcement. Give it unsolicited for behavior you would like to see more of.	Parent walking in, catching the children playing well together, praises them.
When giving tangible or food reinforcers to your child, accompany it with praise... and your child will learn to enjoy praise more than things and food.	Parent paying a child money for a task, praising the child while doing so.
Don't pollute your reinforcers with lectures or instructions.	Parent starting out by reinforcing children, ends up lecturing them "Why can't you be like this all the time, etc?"
What started out as praise...ended in scolding...and the reinforcement value is probably lost. Make your reinforcers clean.	Repeat of same reinforcement scene, no lectures.
Sometimes a child who has been reinforced for good behavior will respond negatively... with self-indulgent or aggressive behavior.	Parent praises child, child responds with a self-indulgent behavior which parent ignores.
That response probably means the child is not used to being reinforced...and does not know how to respond appropriately... a classic case of "he/she can't accept a compliment".	

If you continue to reinforce that child's good behavior, he/she will soon become used to being treated in a positive way.

Is this bribery, you may ask? Bribery also uses a system of rewards to accomplish its ends... but the behavior it encourages is immoral...or illegal.

To be aware of what behavior we are encouraging in our children...and to reinforce the positive...is not bribery.

Parent re-entered room, again reinforces child. This time child responds appropriately.

Bribe scene.

COMMAND COMPLIANCE

Narration

Scene 1

Father looks at the camera and asks, "Why doesn't he do it the first time I ask?"

Because he knows that you will repeat the command many times. . . and that you don't really <u>expect</u> him to comply immediately.

Scene 2

looks at camera and asks, "Why does she wait until I get mad to do as I ask?"

Because she knows that you don't really <u>expect</u> her to mind until you become angry.

Janet on camera.

Parents may not realize that every day they are teaching their children which commands to obey and when to obey them. . . which means that before you can change your child's behavior, you will have to examine you own.

Do you ramble when you are giving a command?

DAD (with train in hand): Jimmy, run out in the garage and get me my toolbox so I can fix this train of yours. If you kids took better care of your things I wouldn't have to be doing this. (Jimmy starts out the door, Dad shouting after him) By the way, while you're out there, make sure the garage door is locked up for the night.

Rambling creates a fog in the child's mind. State your commands clearly. . . and briefly.

State the command once, and once only.

Don't make a question of what you intend to be a command. It may sound more pleasant as a question, but it is insincere if you are unwilling to take "No" as an answer.

Don't overload the child with commands. Too many will overwhelm him/her.

DAD: Jimmy, please bring me my toolbox from the garage. (Jimmy runs off).

(Go back to the scene with Dad reading paper and Jimmy watching TV).
DAD: Go put you pajamas on, Jimmy - it's time for bed.
(No response from Jimmy).
(Dad puts paper down and gets up from chair to head for Jummy).
DAD: No, Jimmy, go put your pajamas on. (Physical assist).

MOM: Jenny, do you want to set the table?
JENNY: No, I'm watching TV right now.
MOM: Well, that's too bad. I need the table set now, because dinner's almost ready.

Dad and Jenny cleaning house with dustmops and stuff in hand.)
DAD: OK, Jenny, we're going to slick this house up and Jimmy and Mom won't even recognize it. Go get the vacuum cleaner,bring it down here, run it over the rug a few times. Go on and get

it now, after that you can dust this room, I'll work on the kitchen, and maybe we'll throw in a load of wash.
(Jenny stares at him blankly, does not move).

Keep the number of commands reasonable so that both you and your child have a chance to follow-through successfully.

DAD: Boy, we'll have this house whipped into shape in no time. Jenny, go get the vacuum.
(Jenny leaves room, Dad begins to dust. Jenny quickly returns with the vacuum).
DAD: Jenny, vacuum the living room, please.
JENNY: OK, Dad.

Once you have given a command. . . your child has two options. To comply. . . or not to. Which consequences you apply to either of those responses will determine which one the child chooses.

If the child complies the first time you give a command. . .

MOM: Jimmy, put the clean dishes in the drainer up in the cupboard.
(Jimmy does so, finishes job, looks up at Mom expectantly. Mom is busy sitting at the kitchen table, writing something).
Jimmy comes up to her and says "All done, Mom," and she doesn't look up, but says "Mm." Jimmy looks despondent, walks away, Mom continues writing.

. . .don't take that response for granted.
Reinforce it. . . immediately. . . warmly. . . and sincerely.

MOM: Jimmy, put the clean dishes in the drainer up in the cupboard.
(Jimmy does so while Mom continues writing at the table. She looks up just as he is finishing and walks over to him).
MOM: Thanks a lot, sweetie. I can always count on you to get the job done in no time at all. You can head on out and play.

What if your child doesn't comply? Give him/her a physical assist through the task.

DAD: Jenny, come here.
(Pause, no response from Jenny, who is sitting in front of the TV set).
DAD: No, Jenny, come here.
(Dad walks to Jenny, takes her by the arm and firmly leads her to him).

Don't lecture or scold. . . simply see him/her through the task. . . and don't let yourself be baited into an argument.

MOM: Jimmy, pick up your toy.
JIMMY: Can't I just play a little longer?
MOM (beginning the physical assist): No, Jimmy, pick up your toys, we have to go to Grandma's house now
JIMMY: You never make Jenny pick up her toys.

MOM: That is simply not true. I treat both of you equally.
JIMMY: She never has to do anything cuz she's little and she's a girl.
MOM: I don't have to listen to this (getting angry). You know that's not true! (Off she stomps, dragging Jimmy with her).

The arguing. . . like rambling. . . creates a fog and the initial command is lost in it. So bite your tongue if you have to.

MOM: Jimmy, pick up your toys. It's time to go to Grandma's.
JIMMY: I don't want to, can't I play a little longer?
MOM: No, Jimmy, pick up your toys.
JIMMY: You never make Jenny do it. I saw you in her room picking up her dolls and things. She never has to do anything!
(Mom completes physical assist without saying a word.)

Once you have begun a physical assist, follow it through to the end. . .whether or not your child cooperates. . .and even if he/she insists that he/she can now do it alone.

DAD: Jimmy, put your train set away now, it's time for school.
(Jimmy continues to play with train).
DAD: (beginning physical assist): No, Jimmy, put your train away.
Jimmy: OK,OK, I can do it, I can do it.
(Dad backs off. . . Jimmy runs the train over in the direction of the toy shelf, then takes an

abrupt turn and starts fooling around again).

DAD: Jimmy, you said you could do it. Come on.

By not complying the first time, the command is made. . .the child should lose his/her chance to do it on his/her own.

Repeat of above scene, but with Dad following through on physical assist.

When you have completed the physical assist, drop the subject. . .completely.

Mom walks into kitchen, discovers Jenny up on the counter.

When a child is already breaking a house rule. . .rather than commanding "Stop that! or "Don't do that!". . . say "No," state the house rule simply, and give the child a physical assist. Don't wait for your child to comply.

MOM: "No, Jenny, we stay off the counters." (Physical assist).

If you find yourself always on the verge of "Don't do that." you might examine some of the "don'ts." It's easy to fall into a habit of forbidding behavior without too much reason.

MOTHER (to child on the way out the door): DON'T get your shoes wet, and DON'T let the cat out. . . and <u>PLEASE</u>, DON'T slam the door! (Child looks at Mother blankly).

Too many "don'ts" set up a child to disobey.

How much compliance is it reasonable to expect from a child? A child who is 100% compliant is probably not developing much of an independent personality. . . so as pleasant as complete obedience might seem, you may have to settle for a little less in the child's best interests.

Lifestyles, personalities, and expectations vary so much from one family to another. . . that only you can judge what is realistic for a child in your family. . . if your child were compliant 75% of the time, we'd consider that pretty good. . .wouldn't you?

Janet on camera.

SECTION ii

APPENDIX B

CHILD NEUROLOGY CLINIC
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AGGRESSIVE BEHAVIOR

The best way to get rid of many undesirable behaviors in children is to ignore them when they occur. However, some behaviors that children engage in cannot be ignored, and these are what we call physically aggressive behaviors. Physical aggression can include many different behaviors: hitting, kicking, throwing, biting, spitting, pushing, scratching, destroying, etc. For our purposes here, we will define aggression as any behavior that is physically hurting to either people or objects.

WHEN BEHAVIOR OCCURS:

The procedure to use when your child is aggressive is called TIME OUT. Literally, it means the child must take "time out" from his normally pleasant environment for a specified amount of time, after he has committed an aggressive act. TIME OUT is punishing to the child because it is boring. The TIME OUT spot can be a bathroom, a chair in a corner or in a laundryroom, or anywhere in which there is little for the child to see or do. Many parents send children to their bedrooms for punishment and this is a form of TIME OUT. However, if the child enjoys playing in his bedroom or lying on his bed, this may not be a punishment but actually a reward. Therefore, the child's bedroom is probably not the best place for TIME OUT.

TIME OUT is a very effective procedure to use to decrease undesirable behavior. However, it must be done correctly by the parent in order to be effective. The following are a list of rules to follow when putting your child in TIME OUT.:

1. Immediately after the aggressive behavior occurs, go to the child and say "Tommy, you hit. You have to go into TIME OUT."
2. March the child to the TIME OUT spot without saying another word. (Don't get drawn into an argument).
3. Have a timer handy and set it for 3 minutes or 5 minutes, whatever you have previously decided upon as the appropriate amount of time for your child.
4. Say "you must sit here until the timer goes off".
5. Walk away and don't say another word to the child until the timer goes off.
6. When the timer goes off, say "You can come out now" and then completely drop the subject. Don't give extra attention after TIME OUT, but don't carry a grudge either.
7. If the timer goes off and the child is not sitting quietly, but is crying, yelling or kicking, say "You weren't sitting quietly when the timer went off. I have to reset the timer".

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8. If you have to reset the timer, go through the same procedure; same rules apply. If child is still not quiet when timer goes off a second time, reset it again.

9. If the child comes of of TIME OUT, march him right back immediately and say "You weren't sitting quietly. I have to reset the timer."

10. If you continue to have trouble with your child coming out of TIME OUT over several different sessions, you may have to institute a separate punishment procedure for when he does come out.

WHEN BEHAVIOR DOES NOT OCCUR:

You will want to reward your child for engaging in behaviors that are incompatible with aggressive behavior; i.e. playing nicely with other children, etc. How often you should praise and reward your child for not being aggressive depends on how often your child performed aggressive acts to begin with. For example, if you observed your child physically hurting other children at a rate of 3 times a day, you will want to praise or reward your child at least that often for not engaging in aggressive activities. Get in the habit of noticing when your child is playing cooperatively and compliment her/him for doing so. Make that behavior pay off and you will begin to see more of it.

FIGHTING BEHAVIOR, AND WHAT TO DO ABOUT IT:

Frequently not one child, but two or more are involved in aggressive behavior, fighting. When two or more children are involved in a physical fight, use TIME OUT with both children, placing them each in a different TIME OUT spot (two bathrooms, two corners, a bathroom and a laundryroom, etc.). Don't try to figure out who started the fight; both children contributed so both have to go to TIME OUT. This keeps you as the parent out of the role of referee, and it also encourages the children to work together to prevent physical fights and the subsequent TIME OUT.

Likewise, if both children are receiving TIME OUT for fights, they should both share in the rewards for playing well together without fighting. How about walking out and handing them each a cold drink for playing a game together without fighting? Or letting them stay up an extra half hour for no fights all evening? Or just praising them on how nicely they are playing? Not only will they work together to prevent TIME OUT, they'll do so to earn your praise and rewards for good play behavior.

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COMMAND COMPLIANCE

Getting a child to mind or obey when told to do something is a common source of problems and frustration for many parents. Another term for minding is what we call command compliance - that is, the child's compliance to the parent's commands. What parents may not realize is that they teach their children to mind or not to mind and in what situations to do so. One common pitfall parents have is repeating a command to a child several times - this teaches a child to wait for the second, third and fourth repetition before responding to a parent's command. Or a child might learn to wait to hear a certain tone of voice before choosing to mind.

Thus, the consequences for minding or not minding largely determine how a child will respond when given a command. If parents wish to increase their children's command compliance, they need to change their own behavior in giving commands and consequences to their children. The following is the method the Clinic recommends to increase command compliance (This method is not recommended for use with older children over whom a parent does not have physical control).

HOW TO GIVE COMMANDS

1. State your commands clearly and briefly.

2. State your commands only once. Do not repeat them.

3. Give commands in the form of a statement, not a question. Asking a question implies that you are willing to accept "no" for an answer.

4. When you give a command, be in a position to follow through with the proper consequences. If you cannot follow through, avoid giving the command.

5. Avoid giving a large number of commands to your child. This will help both you and your child follow through when you do give a command.

WHEN BEHAVIOR OCCURS - What to do when your child minds you the first time you give a command .....

REINFORCE THAT BEHAVIOR!

Praise your child for minding you and do it with feeling! We all like recognition for a job well done, and your child is no exception. If you let your child know you genuinely pleased you are with the good behavior, you will see more of that behavior.

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WHEN BEHAVIOR DOES NOT OCCUR - What to do when your child does not mind you the first time you give the command .....

1. State your command and give your child a reasonable amount of time to comply.

2. If your child does not comply, say "No" then restate the command as you physically lead your child through the task.

   Ex. DAD: "Mary, come here."

   (Pause, no response from Mary)

   DAD: "No, Mary, come here." (Dad walks to Mary, takes her by the arm and firmly leads her to him)

   Ex. MOM: "Jimmy, pick up your toys."

   JIMMY: "No, I don't want to."

   MOM: "No, Jimmy, pick up your toys." (Mom walks to Jimmy, takes him by the back of his hand and physically leads him through the task of picking up his toys)

3. Say nothing else to your child during the physical assist procedure. Do not lecture or scold. Don't get baited into an argument.

4. Follow through completely during your physical assist, even if your child does not want to cooperate and even if your child insists that he can now do it on his own. By not complying with your command the first time, he lost his chance to do it on his own.

5. When you have completed the procedure, drop the subject completely.

ROUTINE NONCOMPLIANCE

When a young child does something that is a "no-no", such as getting into the kitchen cupboards, or when an older child fails to do something he should know to do without being asked, such as hanging his coat up, this is routine non-compliance. In such cases, you should not need to give a command--you have an unspoken command around your house that certain things should be done and other things should not be done.

WHEN ROUTINE NONCOMPLIANCE OCCURS - Dispense with the initial command (it is unspoken) and go immediately into the correction procedure.

Ex. Parent finds child climbing on kitchen cupboards. Parent walks up to child and says

"No, David, stay out of the cupboards" while physically lifting him off the counter.

Ex. Parent finds that child has thrown her coat on the floor after school. Parent approaches child and says

"No, Jenny, hang your coat up" while physically assisting her to pick the coat up and following through with the hanging up of the coat.

WHEN ROUTINE COMPLIANCE OCCURS - i.e. when the child does what is routinely expected of her without being told--reinforce and praise the child for doing so.

Ex. When David has stayed out of the kitchen cupboards all morning:

"David, you've done such a good job playing with your own toys." or "David, you've stayed out of the cupboards all morning. Thank you very much."

Ex. When Jenny remembers the garbage without being reminded:

"Jenny, thanks for taking out the garbage. It was extra full tonight!"

Self Initiated Toileting

Terminal Objective: Child will use toilet unassisted, without a cue, 90% of the time for 3 consecutive weeks.*

Phase I: Child will use the toilet upon verbal request alone.

Step 1: Give cue "_____, go potty." "_____, what do you have to do?" Correct response = child responds with "Go potty."

Step 2: Give cue"_____, what do you have to do?" Correct response = "Go potty."

Step 3: One-half hour before potty time, say "_____, take yourself to the potty when you need to go."

Step 4: One hour before potty time say "_____, take yourself to the potty when you need to go."

Phase II: Child voluntarily uses potty when necessary.

Step 1: Once a day

Step 2: Twice a day

Step 3: Three times a day

Step 4: Four or more times a day

*Note: This program is to be conducted with a child who is already toilet trained (see toilet training program) and no longer in diapers, but who continues to need assistance in using the toilet.

CHILD NEUROLOGY CLINIC
BEHAVIOR PROGRAM SHEET

CHILD'S NAME: Debbie

TARGET BEHAVIOR: Decrease Debbie's physically aggressive acts (includes hitting, kicking, scratching and biting.)

FINAL GOAL FOR BEHAVIOR: No more than 3 occurrences per day.(no more than twice/week) (Final goal should be maintained for at least three weeks to consider program successful)

BASELINE DATE AND DATA: 9/6/77-9/4/77 -- 2.5 occurrences per day

DATES (Beginning & Ending)	DATA	PROGRAM INSTRUCTIONS	
		When Behavior Occurs	When Behavior Does Not Occur
Baseline	2.5/day	Parent will put Debbie in "Time Out"	Parent will praise Debbie at least three times a day for behaviors incompatible with aggression behaviors. (playing nicely, etc.)
9/27/77-10/3/77	.85/day	Continue	Continue
10/4/77-10/10/77	No Data	Parents on vacation	Debbie's sitter did not keep data
10/11/77-10/18/77	1.3/day	Continue program from before vacation.	
10/19/77-10/25/77	.8/day	Continue-family is just now getting back into routine	
10/26/77-10/31/77	.8/day	Continue	Continue
11/1/77-11/7/77	.8/day	Continue	Continue
11/8/77-11/14/77	.29/day	Contineu	Parent will add a special privilege in the evening as a reinforcer to Debbie for no aggression that day.
	.29/day	Continue-below goal for one week	
11/15/77-11/21/77	1/day	Continue -below goal for	second week.
11/22/77-11/29/77	.38/day	Oops' Parents inconsistent with	program over
		Thanksgiving holiday -	continue program consistently
11/30/77-12/5/77	.29/day	Continue	Continue
12/6/77-12/12/77	.29/day	Continue-below goal for	one week
12/13/77-12/19/77	.29/day	Continue - below goal	for second week.
12/20/77-1/2/78	.14/day	Continue - parent was	urged to be as consistent with
		the program as possible	over the Christmas holiday.
1/3/78-1/9/78	.14	Program has met its goal	, parent willnow offer the evening privilege noncontingent upon the absence of aggressive behavior-i.e. Debbie gets the privilege routinely just for being a "good girl" that day.

CHILD NEUROLOGY CLINIC
BEHAVIOR PROGRAM SHEET

Continued

CHILD'S NAME: Debbie

TARGET BEHAVIOR: Decrease DEbbie's physically aggressive acts. (includes hitting, kicking, scratching and biting.)

FINAL GOAL FOR BEHAVIOR: No more than 3 occurrences per day. (no more than twice/week.) (Final goal should be maintained for at least three weeks to consider program successful)

BASELINE DATE AND DATA: 9/6/77-9/4/77 -- 2.5 occurrences per day.

DATES (Beginning & Ending)	DATA	PROGRAM INSTRUCTIONS	
		When Behavior Occurs	When Behavior Does Not Occur
1/10/78-1/16/78	0/day	Spot check the behavior	one day a week
1/17/78-1/23/78	Program successfully completed - spot check once a month for next two months.		

CHILD NEUROLOGY CLINIC
BEHAVIOR PROGRAM SHEET

CHILD'S NAME: Shawn

TARGET BEHAVIOR: That Shawn will follow parental directions upon first command

FINAL GOAL FOR BEHAVIOR: 75% of commands
(Final goal should be maintained for at least three weeks to consider program successful)

BASELINE DATE AND DATA: 2/2/78-2/28/78 -- 25%

DATES (Beginning & Ending)	DATA	PROGRAM INSTRUCTIONS	
		When Behavior Occurs	When Behavior Does Not Occur
Baseline	25%		
3/2/78-3/8/78	38%	Parent will praise child each time	Parent will verbally correct and physically assist child through task.
3/9/78-3/16/78	44%		
3/17/78-3/28/78	56%	Continue	Continue
3/26/78-4/1/78	40%	Continue	Continue
4/2/78-4/9/78	61%	Parent will praise more consistently after each success	Parent will follow through more consistently every time
4/10/78-4/17/78	60%	Continue	Continue
4/1/78-4/25/78	59%	Continue	continue
4/26/78-5/3/78	76%	Parent will add a small food reinforcer to pair with praise	Continue
5/4/78-5/10/78	66%	Continue- Shawn is above goal for one week	
5/11/78-5/17/78	77%	Shawn was ill last week- continue program this week	
5/18/78-5/24/78	81%	Continue-above goal again for one week	
5/25/78-5/31/78	80%	Continue-above goal for second consecutive week	
6/1/78-6/7/78	79%	Fade reinforcers from food to praise only	Continue
6/8/78-6/16/78	82%	Continue with praise alone for one more week	Continue
6/17/78-6/25-78	80%	Fade to a spot check on the behavior one day a week	
6/26/78-	Program completed successfully - spot check once a month for the next two months		

CHILD NEUROLOGY CLINIC
BEHAVIOR PROGRAM SHEET

CHILD'S NAME: Glenn

TARGET BEHAVIOR: That Glenn will use the toilet unassisted without a cue from parents

FINAL GOAL FOR BEHAVIOR: 90% on-toilet responses
(Final goal should be maintained for at least three weeks to consider program successful)

BASELINE DATE AND DATA: 10/3/77-10/9/77 - Phase I, Step 2 = 20%

DATES (Beginning & Ending)	DATA	PROGRAM INSTRUCTIONS	
		When Behavior Occurs	When Behavior Does Not Occur
Baseline	Phase I, Step 2		
10/3/77-10/9/77	Phase I, Step 2	Parent will praise Glenn and clap for him	Parent will take Glenn to toilet, but no praise
10/10/77-10/17/77	Phase I, Step 3	Continue above, moving onto next step	
10/18/77-11/3/77	No data	Glenn in hospital for 3	weeks (no notes)
11/4/77-11/10/77	Phase I, Step 2	Begin program again	
11/12/77-11/18/77	Phase I, Step 2	Continue, starting back at Step 2	
11/19/77-12/1/77	Phase II, Step1	Add special privilege for successful response-continue to praise each success	Continue, no praise
12/2/77-12/8/77	Phase II, Step 1	Glenn caught on and began voluntarily using toilet upon occasion, approx. once a day. Provide special privilege for voluntarily use of toilet, pairing it always with praise	
12/9/77-12/16/77	Phase II, Step 4	Continue	Continue
12/17/77-1/5/78	Phase II, Step 4	Glenn is voluntarily using toilet throughout the day. Parent will provide special privilege at end of day throughout holiday season, paired with praise	
1/6/78-1/20/78	Phase II, Step 4	Parent will no longer provide special privilege but will intermittently praise	Parent will no longer take Glenn to bathroom at any time
1/20/78	Program successfully completed-parent will no longer conduct formal program	but will observe closely for next two months	

SECTION ii

APPENDIX C

CHILD NEUROLOGY CLINIC
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PARENT SKILL GROUP:

Session I: Baseline

A. Pretest.
B. Baseline-lecture (materials: baseline handout).
   1. Definition.
   2. Format on data sheet (vertical): decide to proceed through phases or steps.
   3. Testing procedures: two trials at each component, begin at most difficult phase and step, continue until child responds 2/2 correct, reinforce attending but not correct responses, use standardized cube but no correction procedure.
C. Baseline practice examples
   1. Decide to proceed through phases or steps.
   2. Format on data sheet: Reverse order, proceed vertically, two trials per component.
   3. Sampled data: decide which component to proceed to next, when to terminate testing.
D. Homework
   1. Set up sample baseline format on given example (with no data).
   2. Discuss appropriate home program with child's teacher and obtain task analysis of this program.

Session II: Individual program preparation

A. Review homework example.
B. Review baseline handout.
C. Parents individually complete program sheet and raw data sheet for their child's home program.
   1. Cue: verbal and non-verbal.
   2. Correction procedure.
   3. Materials, setting.
   4. Criterion.
   5. Data sheet: reverse order, two trials per component, proceed vertically.
D. Practice examples-data completed on baseline.
   1. Decide where to begin teaching within the program.
   2. Begin teaching at one component above "easiest" component where child receives two correct responses.
   3. Update to this phase and step on the data sheet.
E. Homework
   1. Conduct baseline with child at home.
   2. Decide where to begin teaching within the program and update on data sheet.
   3. Implement program for three days.

Session III: Updating

A. Review all baseline on home program for:
   1. Format.
   2. Completeness of testing.
   3. Correct update from baseline.
B. Review three days of data for each home program and identify the following data patterns:
   1. XXXXX-met criterion.

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2. 00X00-two days of little or no success.
3. X0XX0-intermittent success.
4. XXX0X-two or three days success with little or no mistakes.

C. Lecture on updating procedures.
1. Meeting criterion-move to the next phase and/or step.
2. Two days of little or no success.
a. Branch-reduce complexity of the task by writing a new phase or step of intermittent level of difficulty or,
b. Modify cue: verbal or non-verbal or,
c. Change materials or,
d. Change criterion-increase criterion and repeat previous phase/step.
3. Intermittent success-change reinforcer.
4. Two/three days with little or no mistakes.
a. Probe ahead several phases/steps.
b. Probe is conducted with two trials at each component, use a reinforcer but no correction procedure.

D. Review data on home program and update each program.
E. Homework.
1. Conduct program at home for five/seven days and update on daily basis.
2. Consult with classroom teacher as necessary concerning updating or programming difficulties.
3. Consult with classroom teacher regarding a second appropriate program to begin at home.

Session IV: <u>Summary</u>

A. Check agreement on updates for home programs over the past week.
B. Review areas of common difficulty in updating or programming.
C. Each parent independently prepare program and data sheet for second home program to be done as each parent decides is appropriate.
D. Possible mini lectures: maintenance procedures, generalization, task analysis.
E. Post-test.

SECTION ii

APPENDIX D

CHILD NEUROLOGY CLINIC
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Pre and Post-Test

I: Terminology (match the following terms with the correct definitions).

1. Baseline-data collected on a behavior that occurs before teaching is initiated.
2. Probe-periodic check in data collection to validate progress of a child or to determine skills in phases/steps ahead of current teaching level.
3. Correction procedure-procedure employed during teaching when a child makes an incorrect response or fails to respond to a programmed cue.
4. Reinforcement-a consequence that increases the probability of occurrance of preceeding behavior.
5. Task analysis-the process of breaking a complex task into smaller steps that can be taught in sequence.
6. Update-daily procedure to determine the phase/step for each program for the following teaching session.
7. Phases and steps-components of a task analyzed program.
8. Cue the verbal or non-verbal behavior that does or can be made to influence the occurrance of a behavior.
9. Branching-devising a component of intermediate difficulty between existing phases/steps in a task analysis for the purpose of individualizing a program for a particular child.
10. Criterion-level of acceptable performance of a behavior involving grade, time, distance, etc. in space.

II: Complete one baseline and program sheet(including cues, criterion materials, etc.) for attached task analysis.

III: Update data patterns (show examples illustrating the following patterns).

1. From baseline.
2. Program meeting criterion.
3. Program having intermittant success.
4. Two or three days with few mistakes in the program.
5. Two or three days with little or no success.

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SECTION iii

CLASSROOM SKILL DEVELOPMENT AND BEHAVIOR DATA

TODDLER AND PRESCHOOL CLASSROOM DATA

The following section describes change in the levels of functioning for the individual programs of the Toddler and Preschool classrooms at the Child Neurology Clinic from September 1978 through June 1979. The programs ranged in duration from several weeks to several months and covered a broad range of skill areas including receptive and expressive language, self help, fine and gross motor, and pre-academic skills.

The classroom curriculum is arranged in developmental sequences such that a Placement Test can accurately assess performance at each developmental level. Upon entrance into the classroom a Placement Test is administered to each child in order to determine appropriate individual programs. If appropriate programs are not available for the child in the curriculum, then individual programs are designed using the Child Neurology Clinic Prescriptive Phase/Step model. During the Placement Test, testing is conducted at the most difficult Phase and Step (terminal objective) of each program. The assumption is that if the child can perform correctly at the final Phase and Step, then he has mastered the preceding earlier steps. If the child fails the most difficult step testing will procede through the easiest steps toward the more difficult steps. Testing is terminated when two consecutive tasks in each skill area have failed.

After prospective programs are selected from the initial placement test, the teacher and education coordinator meet with the parents to establish an Individual Educational Program (IEP) for each child. This IEP includes long range and short range goals in all needed skill behavioral areas. The IEP form developed by the Child Neurology Clinic is modeled after certain aspects of the Oregon State suggested model. For a sample of the IEP format used, please refer to Appendix A.

The short range goals in the IEP are the individual task analyzed programs. The long range goals include the total individual programs within a skill area that are projected for the year. At the IEP review meeting with the parents the baseline and current level for each program are discussed in detail. In June, at the end of the school year, the IEP is again reviewed to assess the gains in each skill area achieved by the child. These forms become an important part of the child's permanent record and provide guidance to any future educational setting in which the child participates. Once the IEP is signed it serves as a guide for individual program selection.

A baseline is then recorded for each program. Programs are made up of Phases which are made up of a number of Steps. Phases and Steps represent two different variables that are sequenced into gradations that a child can master one by one. A program might involve several Phases of decreasing the amount of physical assistance for standing while stepwise increasing the duration of standing. Another program might have several color identification Phases while stepwise increasing the number of distracting colors. During the baseline testing, two trials are given at each Phase and Step starting at the most difficult Phase and Step and proceeding to the least difficult. Testing during the baseline is terminated when the child fails to make two correct responses within a Phase and Step. The baseline percentage represents the ratio of components (Phases and Steps) to the total number of program components achieved by the child.

After the program baseline is completed, then the program is initiated with a designated cue, reinforcement, and correction procedure. The programs are conducted daily with trial by trial data collection. Criteria are set for each child and each program to determine the number of correct responses required of the child to advance to a more difficult Phase and/or Step. If the child does not meet the criterion in two days, then changes are made in the cue, reinforcement, or response required of the child. This data is reviewed daily to determine a need for such changes or for an accelerated movement through the program. If a child has not met criterion, a possible change in the program is to write an appropriate Branch. A Branch is written specifically for one child and one program and represents an intermediate gradation between existing Phases or Steps. Thus each program in the curriculum is individualized to each child's needs.

The "current percentage" in the following data is computed by adding the number of components of the program passed at baseline to the number of program components learned and divided by the total program components. Most programs are continued until the child masters 100 percent of the components of the program. A systematic maintenance system is then employed with skill checks at two days, one week, two weeks, one month, and three month intervals. If the skills are not maintained at any of these check points, then the program is re-administered until the child meets criterion.

For the period of July 1, 1978 to June 30, 1979 a total of 25 children participated in the toddler and preschool classrooms. Table 1 provides distribution, by classroom and curriculum area, of the number of programs implemented (also see Appendix B).

Table 1: Number of Skill Programs Implemented in the Toddler and Preschool Classrooms

Receptive Language	53
Expressive Language	47
Fine Motor	36
Gross Motor	6
Self-Help	36
Academic	31
*Fine Motor Exercise	6
*Gross Motor Exercise	8
TOTAL:	222
No. of Children	25
Average number of programs per child	8.8

*Programs administered by a Physical or Occupation Therapist

The individual programs were distributed between six task analyzed curriculum areas and two physical therapy areas. The language area was most heavily programmed with receptive language accounting for 23% of the total programs and expressive language representing 21% of the programs. The least programmed areas were those of academic (14%) and gross motor (3%). Table 2 indicates the percentage breakdown of the total programs implemented by program area.

Table 2: Percent of Programs by Program Area

Receptive Language	23%
Expressive Language	21%
Fine Motor	16%
Gross Motor	3%
Self-Help	16%
Academic	14%
Fine Motor	3%
Gross Motor	4%

All individual programs are selected and implemented after the Placement Testing and development of the Individual Educational Program. Thus the distribution of programs across the program areas may also reflect the parents priorities. Language skills are often the most important skills from a parents viewpoint for a child to acquire. Since most of the children in the Child Neurology Clinic educational program are under the age of 4 years, the relatively small number of academic programs seems appropriate. The data suggesting a lack of motor programs, however, is somewhat deceptive. All children in the program are screened by a physical therapist, who is a full-time staff member of the Clinic. Consequently many of the children receive physical therapy on a regular basis outside of the classroom setting. In addition, many classroom children are on stimulation and exercise programs prescribed and monitored by the physical therapist or an occupational therapist. The format of these motor exercise programs differs somewhat from the task analyzed programs that are usually conducted in the classrooms. The classroom staff of the Clinic work closely with the physical thereapy staff in developing task analyzed gross and fine motor programs to be conducted in the classroom.

In determining the number of individual programs implemented, the most important consideration is that the number of programs be the optimum for each child. That is, there should be programming in needed areas of deficiency yet the number of programs should not be excessive such that they cannot realistically be conducted each day. Another index to the appropriateness of the number of programs conducted is the number of programs meeting criteria (100% of the program components should be learned). Table 3 describes the skill area breakdown of those meeting criteria in the classroom programs.

Table 3: Programs Conducted by Skill Area

	Number Programs	Percent of All Programs	Percent of Programs Meeting 100% Criteria
Receptive Language	N=75	33%	65%
Expressive Language	N=32	14%	38%
Fine Motor	N=27	27%	56%
Gross Motor	N=8	4%	50%
Self-Help	N=27	12%	63%
Academic	N=24	11%	65%
Total	229	100%	59%

In addition to the implementation of individual programs, the toddler and preschool classrooms conduct programs based on a group format. The group format proved to be advantageous and effective when teaching a similar concept or concepts to a number of children. Appendix C of this section provices a format and a sample program. The descriptive material in this Appendix is an extract from the Child Neurology Clinic training manual. The following tables summarize the data generated from the group programs as implemented in the toddler and preschool classrooms.

The classrooms also serve to increase the number of positive, appropriate behaviors and reduce the number of behavior problems. One of the most important factors in this regard is consistency. Whenever an adult delivers a cue to a child (such as "stand up" or "what color is this block"), the adult waits for the child to respond. The adult then either reinforces a correct response or uses a correction procedure if the child fails to respond or responds incorrectly. This correction procedure has several parts which are always delivered in the same sequence. These parts are saying "no", repeating the cue, physically leading the child through the correct response, and then socially reinforcing the child. For example, if a child is given the cue "stand up" and does not stand up, the adult says "no, stand up", leads the child through the process of standing up, and then says "thank you" or uses another similar social reinforcement. Most children quickly learn that the adults will follow through on all cues and thus they behave compliantly.

Another important part of the classroom program is simply to give more attention to the children who are behaving appropriately than to those behaving inappropriately. Children learn that it is more reinforcing to talk and behave positively and appropriately than to talk and behave negatively and inappropriately. This model is very clear for parents and visitors and generalization often occurs from informal observation of the classroom.

As a result of the consistency and selective use of attention to positive behavior, many children who demonstrate aggressive, non-compliant, or self-indulgent behaviors in other settings learn to use positive behaviors to receive attention in the classroom. Children who still demonstrate inappropriate behaviors despite this model are placed on individual behavior programs. Inappropriate behaviors are pinpointed, baselined, and an intervention strategy is planned. Data is collected on a daily basis but it is evaluated on a weekly basis. If the same inappropriate behavior is also demonstrated at home, the parents will become involved in implementing a behavior program at home.

Behavior programs conducted in the toddler and preschool classrooms from September 1978 to June 1979 were conducted for approximately 20% of the children participating in the Child Neurology Clinic classroom programs. Of these, all met the criteria for success which had been specified prior to intervention.

To assess the extent to which the classroom programs affect children's behavior and abilities, a study was conducted during the third project year. The study utilized a single subject multiple baseline design and included twelve of the children enrolled in the preschool and toddler classrooms programs. Data was obtained for children in the classroom setting as well as data obtained from parent taught home based programs conducted under the supervision and direction of Clinic staff. Program areas covered by the study included self help, receptive and expressive language, fine motor, pre-academic, and social skills. The data obtained from the study suggest that the Child Neurology Clinic preschool and toddler programs are highly effective.

In using multiple baseline techniques, behaviors are identified and measured over a period of time to establish baseline levels against which to assess any subsequent change. For the purposes of this study, behaviors to be taught for each child were randomly placed in groups of three following the establishment of baseline levels. With these groups of three skill areas established, intervention was initiated for one of the three while continuing baseline conditions for the other two. Subsequently, the remaining two skill areas are re-baselined and intervention was initiated for one of these while the third continued under baseline contitions. This procedure was continued in sequence until intervention had been applied to each of the three skill areas. Intervention was determined to be effective when a change occured in the skill areas following intervention while baseline levels for untreated skill areas remained comparatively unchanged. A basic assumption to this approach is that each of the three skills being taught are of different response classes and are therefore independent of each other. If the rates of acquisition of the skills happen to co-vary, then the controlling effects of the intervention are subject to question and imposes limitation upon interpretation.

In order to determine the impact of the classroom instructional model on the children served, it was necessary to compute the number of skills acquired with and without instruction. Once this was completed, a comparison could be accomplished.

Figures 1 through 14 display a sample of individual multiple baseline programs conducted with a sample of students from the Good Samaritan model. Nine students were selected from the toddler and preschool classrooms. The students and programs were selected based upon the sampling procedure previously described. Three programs for each student were sampled to demonstrate the variety of programs and the fluctuation in time that occurs between initial assessment, beginning of the program, and program completion (see Appendix D).

The data further demonstrate that the passage of time without direct instructional intervention produces little change in students' skill levels. It can be observed through repeated measures on individual students that once instruction is implemented the number of new skills acquired increases considerably. Since instructional programs were implemented at different time intervals for the same child and the same measures were taken at placement and before instruction was initiated, these data represent a multiple baseline effect (multiple baseline design across behaviors in a single subject).

To compute gains without instruction, the total number of days that elapse between the Placement Test and the beginning of intervention was divided into the number of new skills acquired during that time period. Results of this computation indicates that a mean of .02 skills per day were acquired by the children without intervention. If this skill rate is projected on a per month basis the average child would have acquired .59 skills per month without intervention. An additional interesting finding, however, is that if the 17 days during Christmas vacation are computed separate from the intervention that occurred before and following that period of time the average skill gain per day is minus .003. If this loss is projected over a month period the average child would have lost .09 skills per month. It is difficult to account for the minor skill gains during baseline (e.g. plus .59 per month) and the loss of skills during the Christmas vacation (minus .09 skills per month) except in the latter condition the children were receiving intervention prior to and following vacation but had not yet met criteria in their respective skill areas.

The number of new skills acquired during intervention was obtained by subtracting the total number of skills present at baseline from the total number of skills present at program termination. By dividing the number of new skills gained under intervention conditions and dividing them by the number of days in which instruction occurred, a mean number of skills acquired per day can be reported. This computation was done for the nine children in the Good Samaritan model. Results of the computation indicated that in the program sampled a mean of plus .16 skills per day were acquired by the children. If this daily rate

is projected over a month's period the average child would have gained 4.69 skills per month per program.

These computations represent progress in a single intervention area. In most cases each student received instruction in approximately 8.7 programs per day. Theoretically then, the daily gains computed for a single intervention area could be multiplied by a factor equal to the number of intervention areas conducted during each day. This computation provides an even further dramatic description of the increase in the new skills when viewed across the student's total daily programs. That is, if the average daily skill acquisition rate of .16 is multiplied by the average number of intervention programs conducted per day, 8.7, then the average daily skill acquisition per child is 1.39 skills per day. Once again, if the 1.39 skills per day is translated into monthly skill acquisition the average child in the Good Samaritan model will acquire 40.77 skills per month.

The data used to compile the computations discussed in the previous section were taken from the information contained in figures 1 through 14.

VII. Impact of the Classroom Interventional Programs:

In order to determine the impact of the home interventional model on the children served, it was necessary to compute a number of skills acquired with and without instruction. Once this was done, comparison could be accomplished. Figures 15 through 18 display a sample of individual programs conducted with a sample of seven students. The students and programs were selected on a random sampling basis. For programs 15 and 16 three intervention programs for each student were sampled (i.e. multiple baseline design across behaviors in a single subject) while in Figures 17 and 18 different intervention areas and children were selected (multiple baseline across subjects). The three programs for each child were sampled to demonstrate the variety of programs and the fluctuations in time that occur between initial assessment, the beginning of the program, and program completion.

Data further demonstrate that the passage of time without the inclusion of direct individual intervention produces little change in the student's skill levels. It can be observed through repeated measures on individual students that once instruction is initiated the number of new skills acquired increases considerably. Since intervention programs were initiated at different time intervals for the same child or at different time intervals for different children these data represent a multiple baseline effect.

To compute gains without instruction the total number of days that elapse between the Placement Test and the initiation of intervention was divided by the number of new skills acquired during that period. The results of this computation indicate that a mean of minus .04 skills per day were lost by the children. If this figure is adjusted on a monthly basis the average child not involved in a home intervention program would lose minus 1.17 skills per month.

The number of new skills acquired during intervention was determined by subtracting the total number of skills present at baseline from the total number of skills present at intervention termination. By totaling the number of new skills gained under instructional conditions and dividing them by the number of days in which instruction occurred, the mean number of skills acquired per day can be reported. This computation was done for the seven children in the Good Samaritan model. Results of this computation indicate that in the intervention areas sampled, a mean of plus .23 skills per day were acquired by the children in home intervention programs. If this figure is projected over a month the average child in a home intervention program conducted by his caregivers will acquire 6.75 skills per month. In the sample group an average of 1.71 programs were conducted. Consequently, if the average number of programs conducted per month is multiplied by the average skill gain per month (i.e. 6.75) then the result is an average gain of 11.57 skills per month for those children involved in home intervention programs.

VIII. Student Gains on State Administered Student Progress Records:

As of the date of this document the results for all children enrolled in the Good Samaritan model has not been analyzed. However, being the Student Progress Record is a skill based assessment device it is anticipated that gains as measured on this document will be significant. Gains made by the children enrolled in the Good Samaritan model will be compared with skill gains made by children not enrolled in a diagnostic prescriptive classroom model.

SECTION iii

APPENDIX A

PRESCHOOL AND TODDLER CLASSROOM DATA

STUDENT PROGRESS RECORD

Individual Education Program
Placement Action Form

Name M. G. Birthdate _____

Address _____ Telephone _____

School Child Neurology Clinic Date of Meeting _____

District of Residency _____

In Attendence at IEP Meeting Susan M. Cook, Susan Holstrom, _____, _____, _____

1. Is special physical education programming required? ____Yes X No
Describe program (if there are specific objectives include on attached pages).

_____

2. Related Services:

X Speech Therapy (describe) Consultation

___ Physical Therapy (describe) _____

___ Occupational Therapy (describe) _____

___ Work Experience (describe) _____

___ Medical Services(describe) _____

___ Social Services (describe) _____

___ Transportation _____

X Other Parent Training _____ _____

_____

3, Recommended Least Restrictive Placement. Entry data January '78 School C.N.C.

Program Pre-school Teachers S. Cook, D. Nasmythe, _____

Describe with Justification: Review data: _____

Developmentally Delayed - no expressive language

_____

_____

STUDENT PROGRESS RECORD

Individual Education Plan

Name: M. G.

Demographic Information: (Describe):

- ☐ Vision Impaired
- ☐ Hearing Impaired
- ☐ Physical Disability
- ☐ Neuorological Impairment
- ☒ Other Developmentally Delayed - no expressive language

School Child Neurology Clinic Year(s)

Date Initiated Person(s) Completing Form

Susan M. Cook

Date Reviewed

Comments:

4. Describe and give time estimates of the extent to which student will participate in the regular program.

5 days a week from 9:00 - 12:00

5. Parents' Responsibilities

1. Attend Parent Training
2. Work in classroom one morning a week

The Child Neurology Clinic model is formulated on the principles of individualization of programs with a comprehensive curriculum emphasizing self help skills, motor development and language. Each program is task analyzed (broken down into small steps and /or phases) and is reviewed by the teaching staff on a daily basis. In-depth details of the classroom model are outlined in the book "A Data Based Classroom" by H.D. Bud Fredericks, et. al, and is available to you for review.

C.A.L.

Parent Signature _____ Date _____

O.L.

Parent Signature _____ Date _____

CHILD NEUROLOGY CLINIC

2222 N.W. Lovejoy, Suite 361

Portland OR 97210 (503) 229-7220

INDIVIDUAL EDUCATION PROGRAM

Name M. G. Date

Priority	Long Range Objectives
1.	Increase expressive verbal language
2.	Increase signing language
3.	Increase receptive language
4.	Increase pre-reading skills
5.	Increase fine motor skills
6.	Increase recreation skills
7.	Decrease inappropriate behaviors
8.	
9.	
10.	

Long Range Objective: #1 Increase expressive verbal language

Short Range Objectives:

1. Imitate the sound $\bar{e}$
   8 of 10 trials correct
   two days in a row.
2. Imitate the sound p
   8 out of 10 trials correct
   two days in a row.
3. Imitate the sound m
   8 of 10 trials correct
   two days in a row.
4. Imitation of words
   8 of 10 trials
   two days in a row.

Short Range Objective	Baseline Date	Baseline Data	Program Initiated	Program Termina Date	Data
1. Sound $\bar{e}$		0/4 0%			4/4 100%
2. Sound p		3/4 75%			4/4 100%
3. Sound m		0/4 0%			4/4 100%
4. Sound $\overline{oo}$		0/4 0%			4/4 100%
5. Sound $\breve{a}$		4/4 100%			4/4 100%
6. Sound wa		0/4 0%			32/32=100%
7. Sound mama		0/4 0%			4/4 100%
8. Sound dede		0/4 0%			4/4 100%
9. Imitates "Bus"		0/4 0%			2/4 = 50%

Long Range Objective: #2 Increase signing to discriminate between 3 signs

Short Range Objectives:

1. Learns the sign "cookie"
2. Learns the sign "drink"
3. Signs "cookie" and "drink" when presented in a random order
4. Learns sign for "nut"
5. Signs "cookie, "drink", and "nut when presented in random order

Short Range Objective	Baseline Date	Baseline Data	Program Initiated	Program Date	Termina Data
1. Sign "cookie"		5/6 80%			6/6 100%
2. Sign "drink"		5/6 80%			6/6 100%
3. Sign "cookie" and "drink" in random order					8 of 10 trials correct 10 of 12 days 100&
4. Sign "nut"		3/4 75%			
5. Signs "cookie", "drink" and "nut" in random order					20 days 8 of 10 trials correct
6. Sign ketchup		1/4 25%			100% 4/4 100%

100

Long Range Objective: #3 Increase receptive language programs C and F in the Teaching Research Curriculum

Short Range Objectives:

1. Responds to name
2. Follows one concept commands
3.
4.
5.
6.
7.
8.
9.
10.

Short Range Objective	Baseline Date	Baseline Data	Program Initiated	Program Termina Date	Program Termina Data
1. Responds to name		0/5 0%			5/5 100%
2.					

Long Range Objective: #4 Increase pre-reading skills/Complete PRS and Phase 1-IV in F in T. R. Curriculum

Short Range Objectives:

1. Finds basic shapes
2. Finds 9 colors
3. Signs names of 4 colors
4. Finds numerals 1-10
5.
6.
7.
8.
9.
10.

Short Range Objective	Baseline Date	Baseline Data		Program Initiated	Program Termina Date	Data
1. Finds basic shapes		4/10	25%			15/16 94%
2. Finds 9 colors		24/36	67%			36/36 100%
3. Signs names of 4 colors		8/20	40%			20/20 100%
4. Finds numerals 1-10		10/40	25%			23/40 57%
5. Signs names of additional 5 colors		8/25	32%			25/25 57%
6. Activity Table Object Positioning		0/6	0%			5/6 83%
7. Activity Table Match Colors (1-IV)		4/16	25%			16/16 100%
8. Activity Table Finds Colors (1-IV)		12/16	75%			16/16 100%

Long Range Objective: #5 Increase fine motor skills

Short Range Objectives:

1. Draws horizontal line
2. Cutting with scissors, Part 1
   Complete cutting independently
   a 6" strip of paper 8 of 10 trials
   two days in a row.

Short Range Objective	Baseline Date	Baseline Data		Program Initiated Date	Program Termina Date	Data
1. Draws Horizontal Line		18/25	72%			25/25 100%
2. Cutting with scissors		8/10	80%			21/21 100%
3. Draws on paper		8/10	80%			10/10 100%
4. Cutting with scissors Part 2		6/21	29%			21/21 100%
5. Cutting with scissors Part 3		0/12	0%			18/18 100%

Long Range Objective: #6 Increase recreation skills A in T. R. Curriculum

Short Range Objectives:

1. Ball skills, roll and throw
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Short Range Objective	Baseline Date	Baseline Data	Program Initiated	Program Termina Date	Data
1. Ball Skills, roll & throw		0/24 0%			24/24 100%
2.					

Long Range Objective: #7 Decrease inappropriate behaviors

Short Range Objectives:

1. Reduce teasing to 5 times per day for 3 consecutive days.
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Short Range Objective	Baseline Date	Baseline Data	Program Initiated	Program Termina Date	Program Termina Data
1. Reduce Teasing		126/day			11 x's/day
2.					

SECTION iii

APPENDIX B

SKILL PROGRAMS

Child	Program Area	Program Title	Baseline	Current Level	% Gain
C.G.	Receptive Language	Body Parts	56	100	44
		Match Objects	8	100	92
		Identify Objects	30	39	9
		Match Pictures	43	100	57
	Expressive Language	Sound Combination	25	71	46
		Sign Words	45	62	17
	Self-Help	Put on T-Shirt	30	90	60
		Put on Pants	77	100	23
	Fine Motor	Shape Box	68	100	32
		Puzzle	20	100	80
		Floor Exercise	90	70	-20
		Table Exercise	60	70	10
	Behavior	Hitting	2x/day	.8/day	1.2
	Writing	Imitate Circle	0	85	85
	Reading	Match Colors	25	71	46
N.S.	Receptive Language	Follow Commands	16	100	84
		Match Objects	0	75	75
	Expressive Language	Motor Imitation	25	100	75
		Imitate Oral Movements	33	66	33
		Imitate Bilabial Sounds	25	25	0
	Fine Motor	Pegboard	37	100	63
M.E.	Receptive Language	Imitate Motor Movements	25	37	12
		Follow Commands	16	33	17
	Fine Motor	Objects Out of Can	100	100	0
	Gross Motor	Directed Locomotion	58	66	8
K.M.	Receptive Language	Follow Commands	36	100	64
		Motor Imitation	25	100	75
	Expressive Language	Imitate Sounds	98	100	2
		Syllable Combinations	44	96	52
	Fine Motor	Shape Box	20	73	53
		Puzzles	23	53	30
		Pegboard	75	92	17
	Self-Help	Use Spoon Independently	80	100	20
	Reading	Match Colors	0	100	100
K.J.	Self-Help	Drink Independently	71	85	14
	Fine Motor	Objects in Container	50	75	25
	Receptive Language	Follow Commands	10	72	62
		Follow Commands	25	75	50
		Imitative Play	50	75	25
		Imitative Play	75	100	25
		Imitative Play	25	100	75
		Motor Imitation	75	100	25
		Motor Imitation	25	25	0
		Motor Imitation	25	75	50
	Gross Motor	Cruising	100	100	0
		Balancing	0	25	25

Child	Program Area	Program Title	Baseline	Current Level	% Gain
J.O.	Self-Help	Remove Shoes	50	75	25
	Fine Motor	Shape Box	36	60	24
		String Beads	11	100	89
		Puzzle	67	70	3
	Receptive Language	Follow Commands	90	100	10
		Match Pictures to Objects	0	96	96
		Identify Objects	62	95	33
		Body Parts	86	100	14
		Opposites	50	50	0
	Expressive Language	Non-Speech Sounds	33	88	55
	Reading	Match Colors	22	75	53
S.R.	Receptive Language	Eye Contact	80	100	20
		3 Concept Commands	27	100	73
		Touch Objects	0	100	100
		Positioning	0	100	100
		Match Objects	93	100	7
		Body Parts	70	100	30
		Identify Action Words	7	57	50
		Identify Objects	57	78	21
		Conditional Clause	31	50	19
	Expressive Language	Say Words	25	33	8
		Imitate Sounds	37	100	63
	Fine Motor	String Beads	0	100	100
		Puzzle	30	100	70
	Reading	Match Colors	41	55	14
M.Y.	Self-Help	Takes Shirt Off	77	100	
		Puts on Socks	60	100	
		Puts on Shoes	25	75	
	Expressive Language	Sign 3 Words	25	100	75
		Says Cheese	33	100	67
	Receptive Language	Follows Command "Get"	50	90	40
		Follows 3 Commands	78	100	22
		Body Parts	53	100	47
		Imitative Play	91	100	9
		Perform Action Words	75	100	25
	Gross Motor	Throws and Rolls Ball	0	100	100
	Fine Motor	Puzzle	33	66	33
		Labels Objects	0	50	50
		Says "No"	0	22	22
		Shape Box	50	80	30
D.W.	Self-Help	Remove T-Shirt	66	100	34
	Gross Motor	Jump Off Box	25	100	75
		Balancing	12	91	79
	Fine Motor	Puzzle	20	100	80
	Writing	Draw Vertical Line	60	100	40
		Hold Pencil	11	100	89
		Draw Circle	28	100	72
		Draw Horizontal Line	28	100	72
	Expressive Language	Sentence Length	32	78	46
		Identify Colors	50	94	44
		Identify Name	62	100	38
	Receptive Language	Positioning	83	100	17
		Conditional Clause Comm.	50	62	12

Child	Program Area	Program Title	Baseline	Current Level	% Gain
T.H.	Expressive Language	Use Full Sentences	20	85	65
		Verbs in Sentences	17	85	68
	Receptive Language	Polar Opposites	27	100	73
		Find Colors	69	100	31
		Conditional Clause Comm.	0	50	50
	Fine Motor	Hold Pencil	11	100	89
		Use Scissors	76	100	24
	Self-Help	Put on Pants	42	100	58
		Put on T-Shirt	30	70	40
		Put on Socks	40	100	60
		Use Zipper	20	60	40
	Fine Motor	Draw Cross	0	66	66
	Number Concepts	Count to 10	10	35	25
	Reading	Identify Name	0	100	100
	Receptive Language	Sound Discrimination	77	100	23
		Positioning	33	100	67
K.D.	Fine Motor	Puzzle	70	100	30
		Puzzle	0	20	20
	Self-Help	Remove Shirt	77	100	23
		Put on Jacket	80	100	20
	Receptive Language	Find Colors	41	100	59
	Number Concepts	Count 10 Objects	83	100	17
	Expressive Language	Name Colors	37	100	63
		Verbal Answers	33	58	25
		Identify Action Words	60	65	5
L.P.	Reading	Match Uppercase Letters	82	100	28
		Find Uppercase Letters	41	78	37
		Identify Shapes	62	100	38
		Identify Name	0	100	100
	Number Concepts	Count 10 Objects	23	100	77
		Rote Count to 20	20	25	5
		Find Numbers 1-12	40	95	55
	Time Concepts	Days of Week	11	100	89
	Expressive Language	Object Function	45	100	55
	Money Concepts	Match Coins	88	100	12
		Find Coins	56	100	44
	Receptive Language	Conditional Clause Comm.	50	100	50
		Learn Left & Right	66	100	34
		Positioning	67	100	33
	Fine Motor	Cut with Scissors	38	100	42
		Draw Square	0	100	100
		Draw Triangle	20	40	20
		Puzzle	80	100	20
		Hold Pencil	33	100	67
T.A.	Receptive Language	Appropriate Play	33	100	67
		Follows One Command	16	100	84
		Follows Three Commands	0	100	100
		Responds to Name	33	66	33
	Fine Motor	Peg in Can	0	100	100

Child	Program Area	Program Title	Baseline	Current Level	% Gain
D.A.	Receptive Language	Identify Action Words	46	100	54
		Match Pictures to Objects	0	100	100
		Polar Opposites	46	100	54
		Unbutton	18	100	82
		Conditional Clause Comm.	0	62	62
		Positioning	66	100	44
		Engage Zipper	20	100	80
	Fine Motor	Puzzle	0	100	100
		Cut with Scissors	28	85	57
		Draw Vertical Line	44	100	56
		Draw Horizontal Line	73	100	27
		Draw Circle	0	100	100
		Draw Cross	0	100	100
	Reading	Identify Name	12	100	88
		Match Uppercase Letters	98	100	2
	Number Concepts	Count 1-10	40	50	10
	Expressive Language	Names Colors	48	85	37
C.H.	Fine Motor	Shape Box	66	100	44
		Cut with Scissors	38	80	42
		Draw Cross	0	33	33
		Draw Vertical Line	60	100	40
	Self-Help	Put Shoes On	14	100	86
		Put Socks On	60	100	40
		Buttoning	0	27	27
	Reading	Finds Basic Shape	58	100	42
		Identifies Name	38	100	62
	Number Concepts	Rote Count 1-10	0	100	100
M.S.	Self-Help	Button Shirt	9	27	18
	Fine Motor	Puzzle	80	100	20
		Cut with Scissors	50	70	20
		Color within a Circle	24	33	9
S.S.	Receptive Language	Follow Commands	35	100	65
	Fine Motor	Objects Out of Can	33	33	0
	Expressive Language	Imitate Sounds	40	60	20
J.C.	Receptive Language	Match Objects	69	81	12
		Body Parts	53	60	7
		Motor Imitation	30	37	7
J.M.	Fine Motor	Puzzle	40	60	20
		Shape Box	90	100	10
		Put on Jacket	90	100	10
B.S.	Reading	Finds Uppercase Letters	14	100	86
	Fine Motor	Colors within a Circle	67	100	33
	Number Concepts	Finds Numbers 1-15	58	100	42

BEHAVIOR PROGRAMS

Child	Setting	Program Title	Baseline	Current Level	Gain
L.B.	Preschool Classroom	Non-Compliance	72	100	28
M.Y.	Preschool Classroom	Out of Seat	1.2/min.	.2/min.	decrease of 1.0/min.
S.R.	Toddler Classroom	Aggression	.7/min.	0/min.	decrease of .7/min.
N.S.	Toddler Classroom	Fussing	1.6/min.	1.4/min.	decrease of .4/min.
N.S.	Toddler Classroom	Throwing Objects	21	100	63

SECTION iii

APPENDIX C

Group Program Description

The following is a sample of a program which can be used when teaching a similar concept or concepts. It is oftentimes too cumbersome to take trial by trial data on individual academic programs at the activity table. Therefore, it may be useful to use some form of group data collection system which relies on presenting fewer trials than the number usually run on individual academic programs.

To facilitate running group programs, it is useful to set up a program that several students need to work on. Each student is then baselined individually to find their appropriate placement. As soon as this task is completed the aide can work with each student at their individual level in the program and take daily data on two of the trials run to determine progress. Correction procedures are used and a student must have two consecutive correct responses before going on to next step.

The usual procedure for running a group program is to run only one or two trials with one student, then a trial or two with another student so that attention is being rotated to everyone at the activity table. Students not involved in the group program should be reinforced intermittently for working on other activities during group programs.

When setting up group programs for a class, it works well to only start out with one or two programs, and attempt to run each of them every day or every other day. If that goal is accomplished and there is ample time for one or two more, then those could be added. It is best to have fewer programs run consistently than to have too many run only occasionally.

When running group programs in a classroom, it is best to schedule related activities prior to or following the group program. Those could include a variety of activities, depending on the concept being taught. Because there is usually time at the activity table to work on related activities, opportunities should be given for students to practice the concepts and skills learned. An example of this would be:

Group Program - Matches, finds or volunteers colors
following activity - song about colors
"What are you wearing?" Art activity
with colored play-dough.

Example #2:

Group Program - Identifies body parts following activity -
"Simon says" game, song "If You're Happy
and You Know It" (stamp your feet, clap
your hands, etc.)

Program Cover Sheet

NAME: Amy, Brian, Jeff

DATE STARTED: 9/10/76

DATE COMPLETED:

TASK OBJECTIVE: 1. Student finds colors red, yellow, blue, green, orange, purple, black, white and brown, three distractors. 2. Student matches colors red, yellow, blue, green, orange, purple, black, white, and brown, three distractors

MATERIALS AND SETTING: 1. colored blocks 2. reinforcers

TREATMENT:

I. CUE OR INSTRUCTIONS:

A. VERBAL: 1. " (name), find (color)"

2. " (name), match (color)"

B. NON-VERBAL: 1. Adult places color blocks on table in front of students

2. Adult places color blocks on table in front of student and hands student block to be matched.

C. CORRECTION PROCEDURE: "No, (name), find (color). Physically assist to make a correct response. Give social reinforcement at completion of task.

CRITERION LEVEL OF ACCEPTABLE BEHAVIOR: 2 consecutive correct responses before going on to next step.

READING SKILLS

E. Finds/Matches Colors

Terminal Behavior: Child finds/matches colors red, yellow, blue, green, orange, purple, white and brown, three distractors.

Note: Colored blocks or construction paper may be used with this skill. Same shaped objects should be used to reduce the variable with which the child must cope.

Phase I	Child finds/matches color red.
Phase II	Child finds/matches color yellow.
Phase III	Child finds/matches color blue.
Phase IV	Child finds/matches color green.
Phase V	Child finds/matches color orange.
Phase VI	Child finds/matches color purple.
Phase VII	Child finds/matches color black.
Phase VIII	Child finds/matches color white.
Phase IX	Child finds/matches color brown.

The following steps apply to each of the phases above.

1. No distractors.
2. One distractor.
3. Two distractors.
4. Three distractors.

GROUP DATA ACTIVITY TABLE

Program: Finds Colors

Cue: "(Name) find (color)"

Phases: red, orange, brown, yellow, purple, blue, black, green, white

Names											
Jan	Date	Jan 4		Jan 5		Jan 8		Jan 9		Jan 10	
	Phase/Step	red	1	red	2	red	3	red	4	yellow	2
	Data	X	X	X	X	X	X	X	X		
Martha	Date	Jan 4		Jan 5		Jan 8		Jan 9		Jan 10	
	Phase/Step	red	4	yellow	3	yellow	3	yellow	3	green	3
	Data	X	X	0	0	ABSENT		X	X		
	Date										
	Phase/Step										
	Data										
	Date										
	Phase/Step										
	Data										
	Date										
	Phase/Step										
	Data										
	Date										
	Phase/Step										
	Data										
	Date										
	Phase/Step										
	Data										

GROUP ACTIVITY BASELINE DATA

lame	Date	Phase	Match 4	Match 3	Match 2	Match 1	Find 4	Find 3	Find 2	Find 1	Volunteer	Date Finished
Jan	Jan 1	red	X X				0 0	0 0	0 0	0 0		
		yellow	X X				0 0	0 0	0 0	X X		
		blue	X X				0 0	0 0	0 0	0 0		
		green	X X				0 0	0 0	0 0	X X		
		orange	X X				0 0	0 0	0 0	X X		
	Jan 3	purple	X X				0 0	0 0	0 0	X X		
		black	X X				0 0	0 0	0 0	0 0		
		white	X X				0 0	0 0	0 0	0 0		
		brown	X X				0 0	0 0	0 0	0 0		
Martha	Jan 1	red	X X				0 0	X X				
		yellow	X X				0 0	0 0	0 X	X		
		blue	X X				0 0	0 0	0 X	X		
		green	X X				X X					
		orange	X X				0 0	0 0	0 X	X		
	Jan 3	purple	X X				X X					
		black	X X				0 0	0 0	0 0	0 0		
		white	X X				0 0	X X				
		brown	X X				0 0	0 0	0 X	X		
Ed	Jan 1	red	X X									
		orange	X X									
		yellow	0 0	0 0	X X							
		blue	0 0	0 0	0 X	X						
		green	0 0	0 0	0 X	X						
	Jan 3	purple	X 0	X X								
		black	0 0	0 0	X X							
		white	0 0	0 0	0 X	X						
		brown	0 0	0 0	0 X	X						

SECTION iii

APPENDIX D

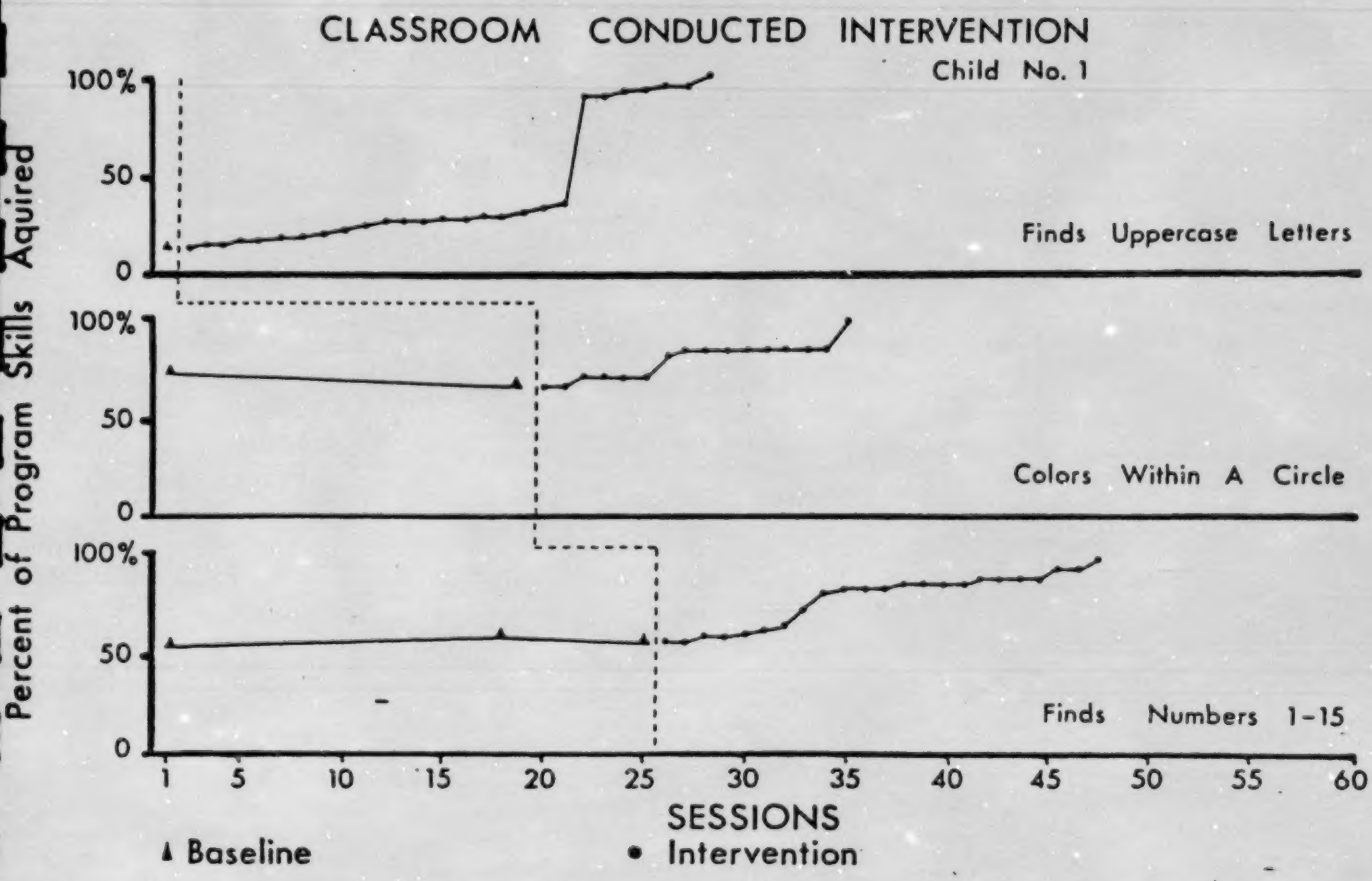
CLASSROOM CONDUCTED INTERVENTION
Child No. 1
Percent of Program Skills Aquired
100%
50
0
Finds Uppercase Letters
Colors Within A Circle
Finds Numbers 1-15
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention

Figure 1

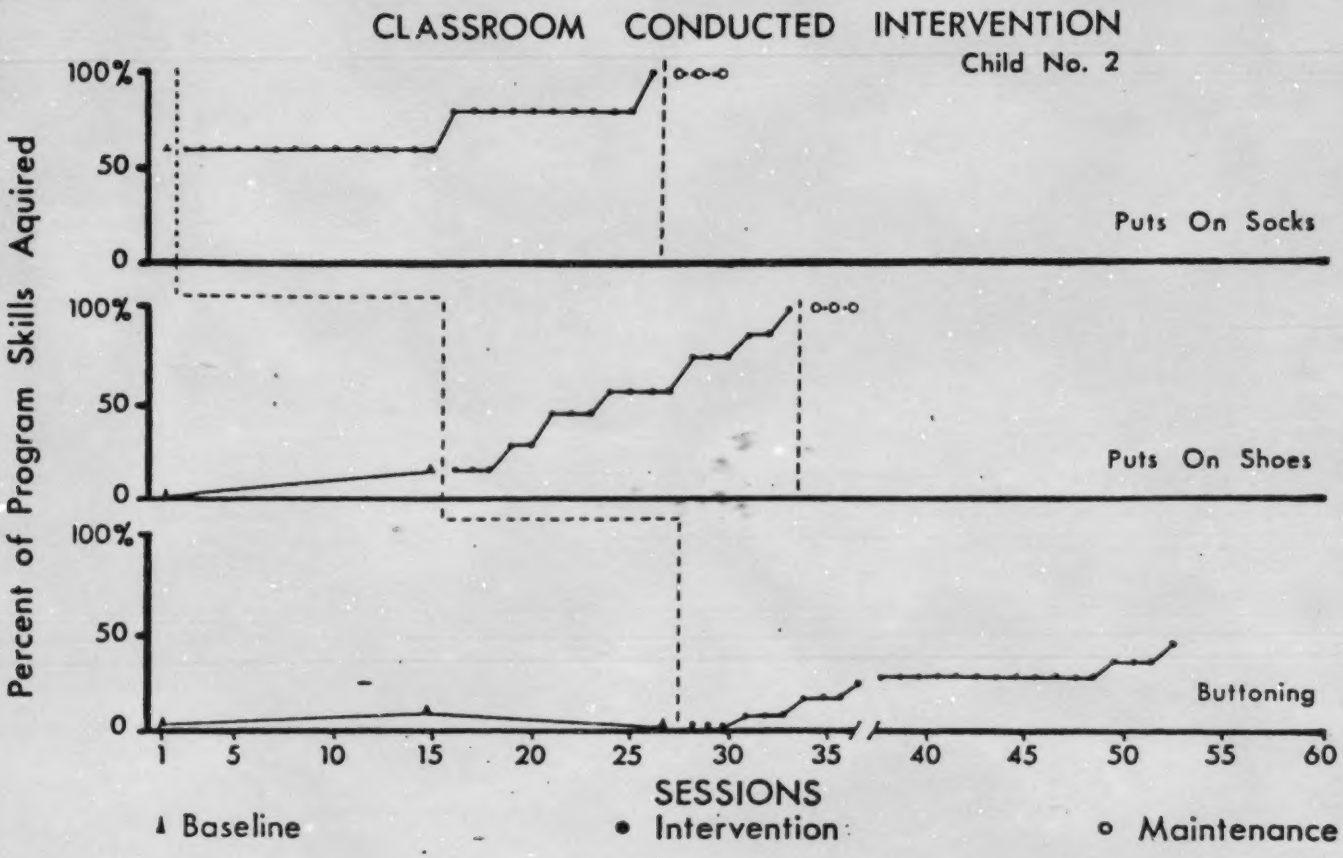
CLASSROOM CONDUCTED INTERVENTION
Child No. 2
Percent of Program Skills Aquired
100%
50
0
Puts On Socks
Puts On Shoes
Buttoning
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention
Maintenance

Figure 2

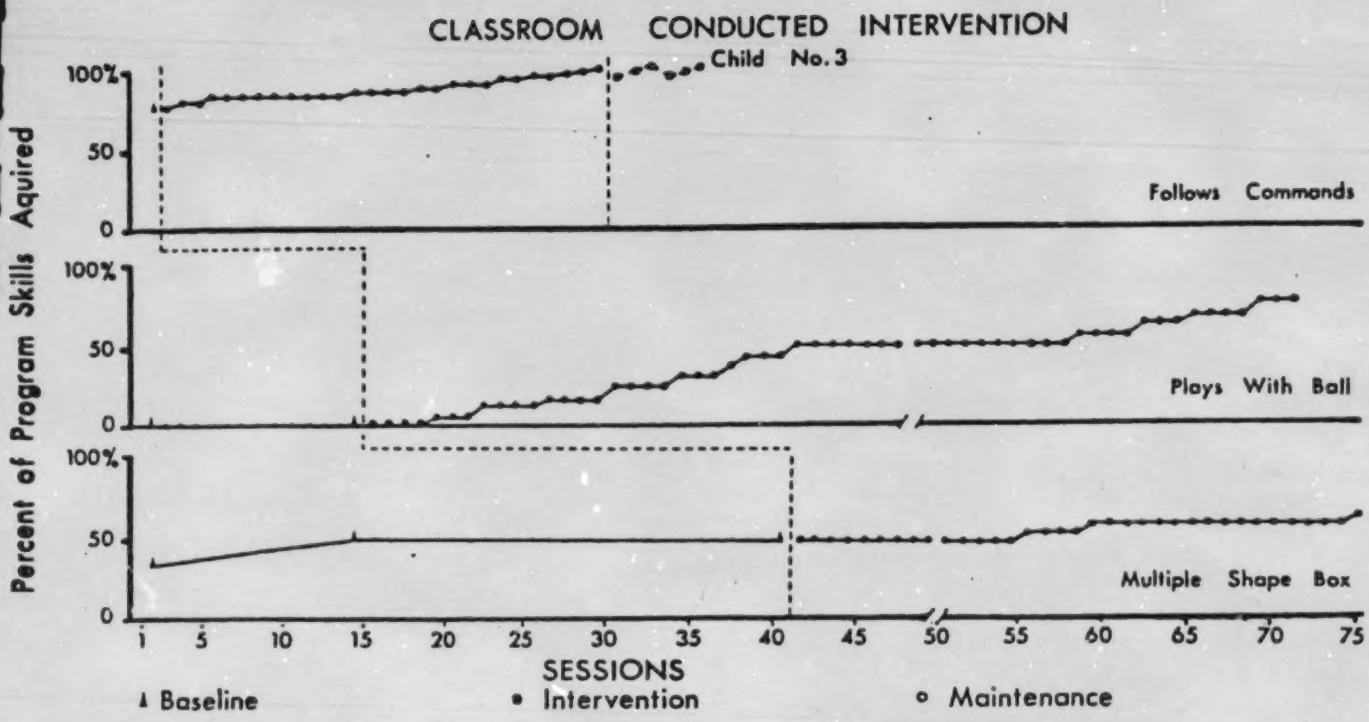
CLASSROOM CONDUCTED INTERVENTION
Child No. 3
Percent of Program Skills Aquired
100%
50
0
Follows Commands
Plays With Ball
Multiple Shape Box
1 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75
SESSIONS
Baseline
Intervention
Maintenance

Figure 3

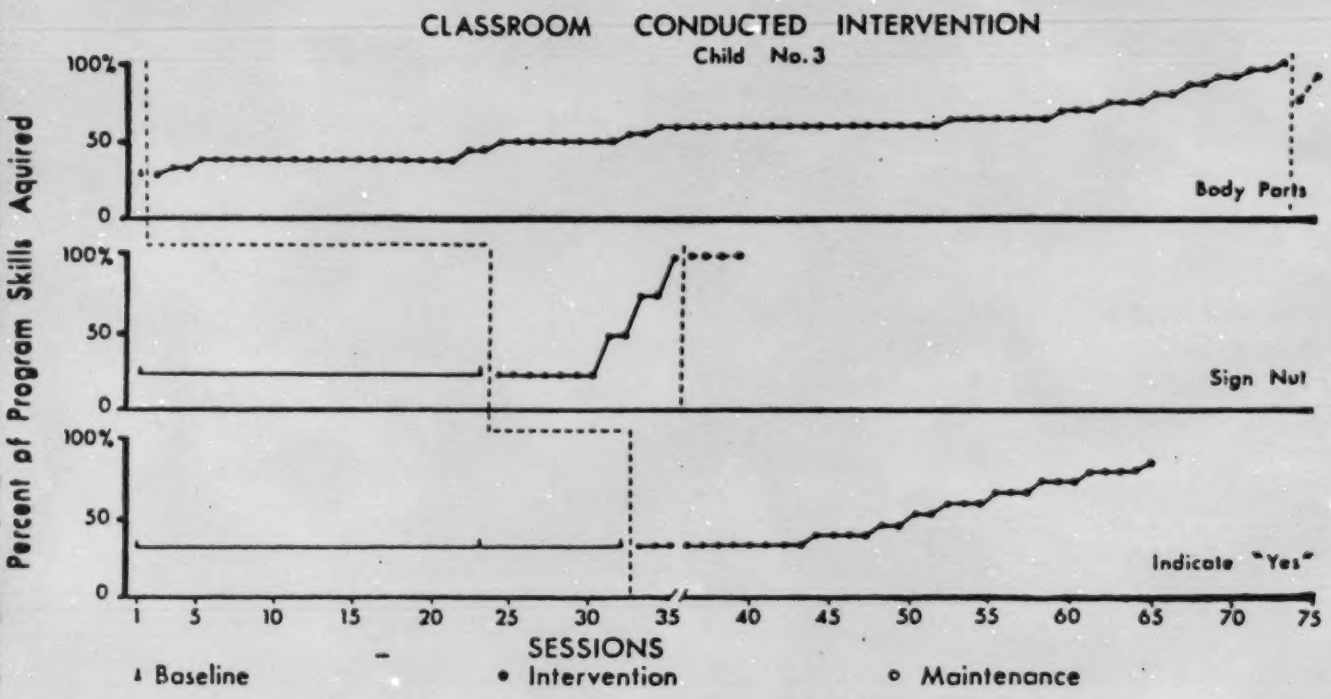
CLASSROOM CONDUCTED INTERVENTION
Child No. 3
Percent of Program Skills Aquired
100%
50
0
Body Parts
Sign Nut
Indicate "Yes"
1 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75
SESSIONS
Baseline
Intervention
Maintenance

Figure 4

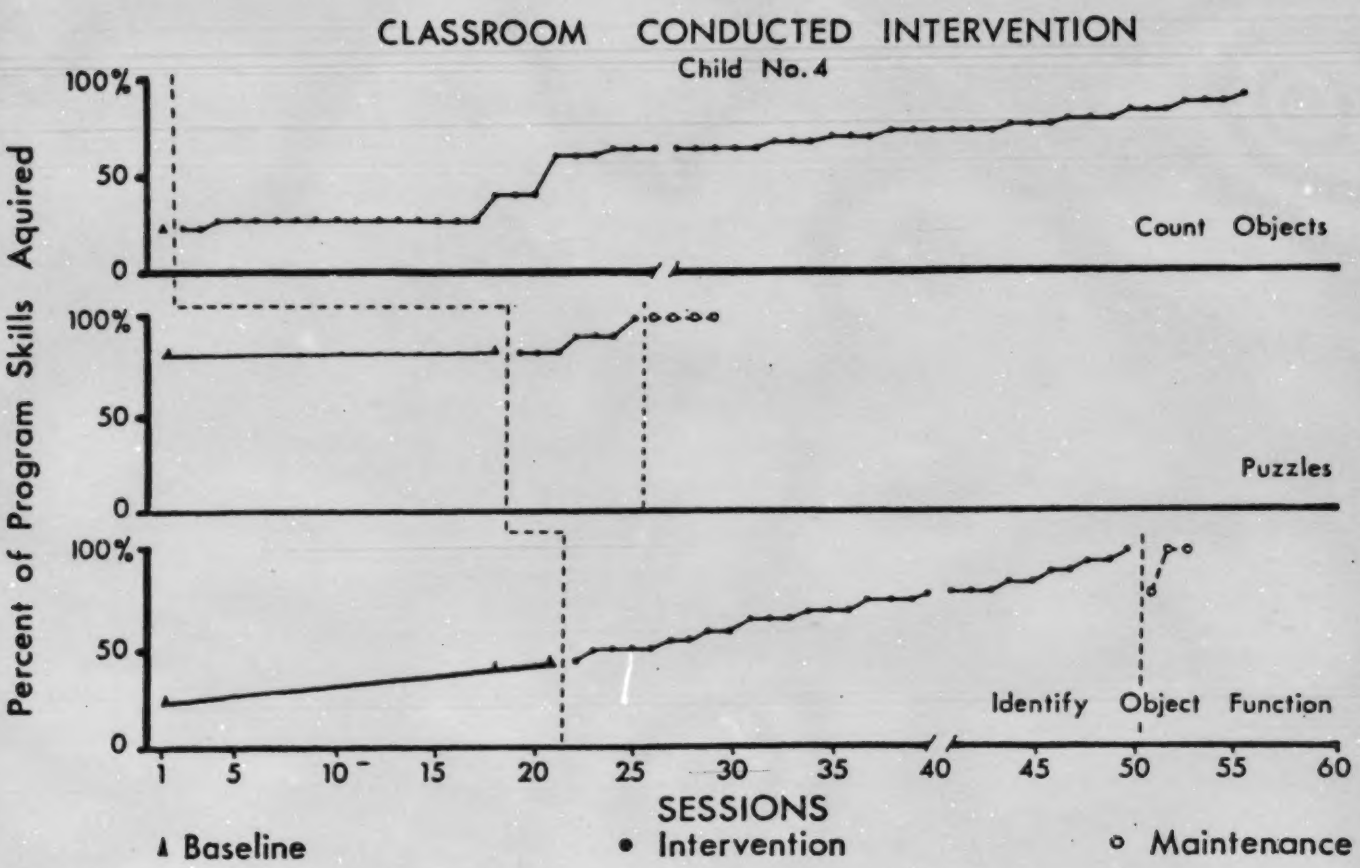
CLASSROOM CONDUCTED INTERVENTION
Child No. 4
Percent of Program Skills Aquired
100%
50
0
Count Objects
Puzzles
Identify Object Function
1 5 10 15 20 25 30 35 40 45 50 55 60
SESSIONS
▲ Baseline
• Intervention
o Maintenance

Figure 5

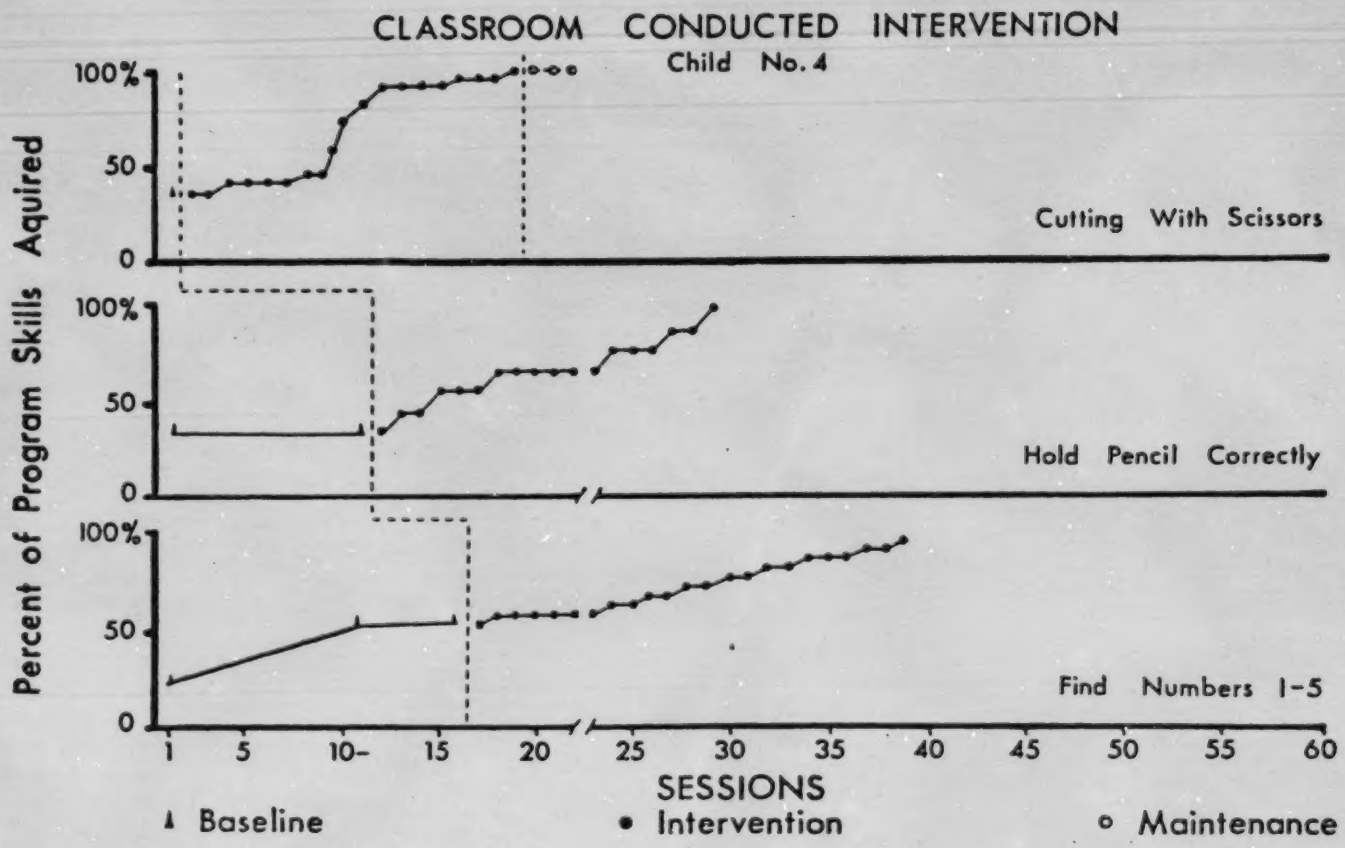
CLASSROOM CONDUCTED INTERVENTION
Child No. 4
Percent of Program Skills Aquired
100%
50
0
Cutting With Scissors
Hold Pencil Correctly
Find Numbers 1-5
1
5
10-
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention
Maintenance

Figure 6

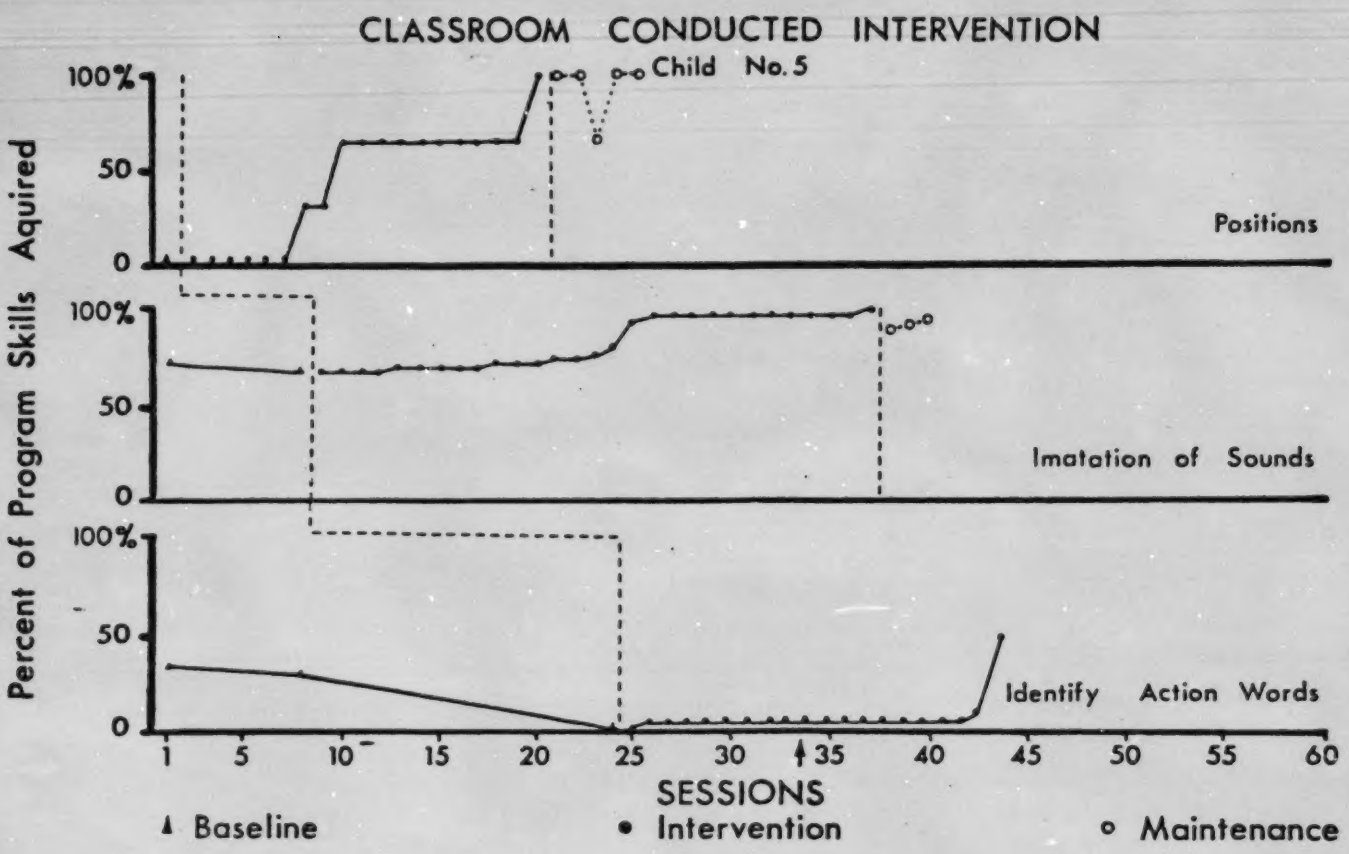
CLASSROOM CONDUCTED INTERVENTION
Child No. 5
Percent of Program Skills Aquired
100%
50
0
Positions
Imatation of Sounds
Identify Action Words
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention
Maintenance

Figure 7

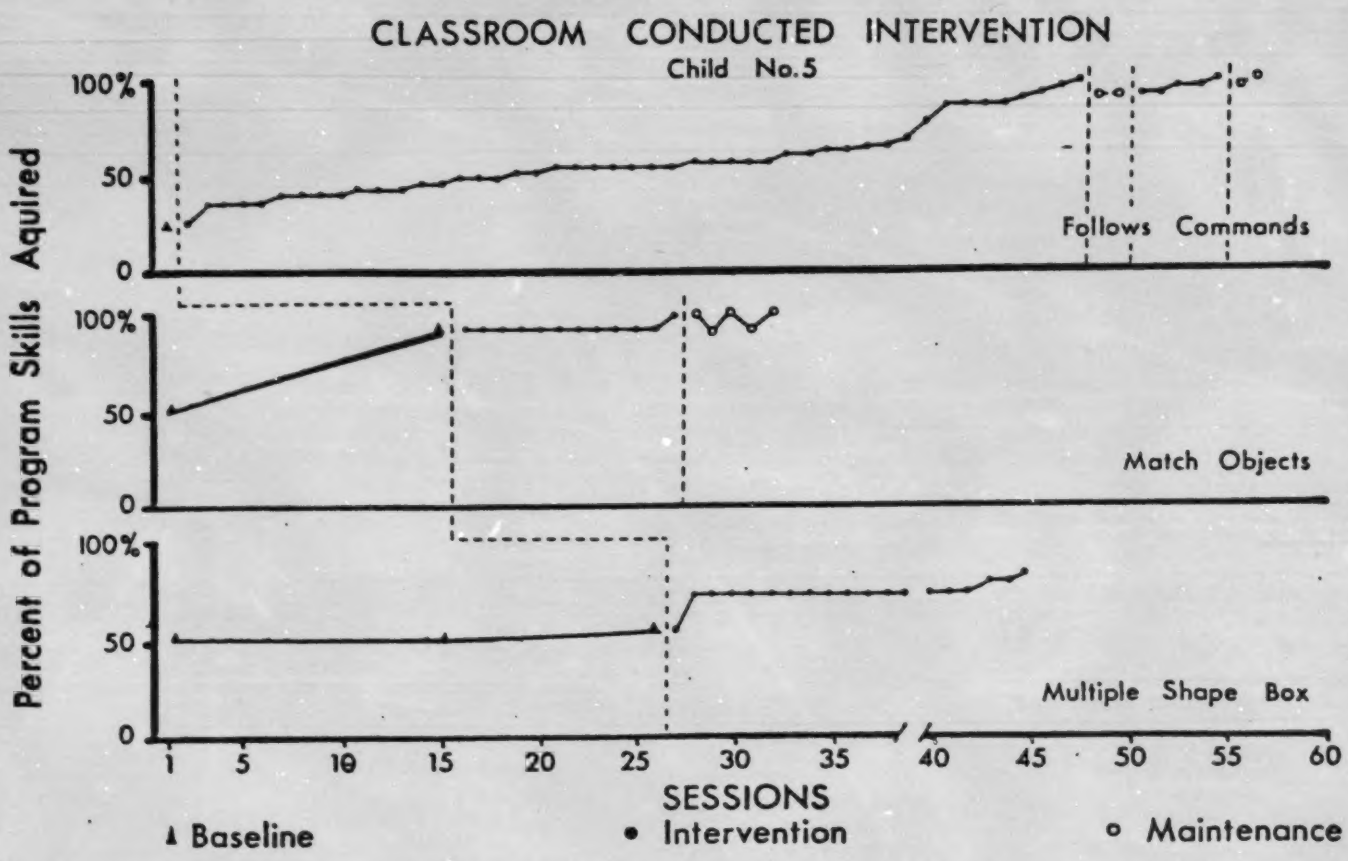
CLASSROOM CONDUCTED INTERVENTION
Child No.5
Percent of Program Skills Aquired
100%
50
0
Follows Commands
Match Objects
Multiple Shape Box
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
▲ Baseline
• Intervention
o Maintenance

Figure 8

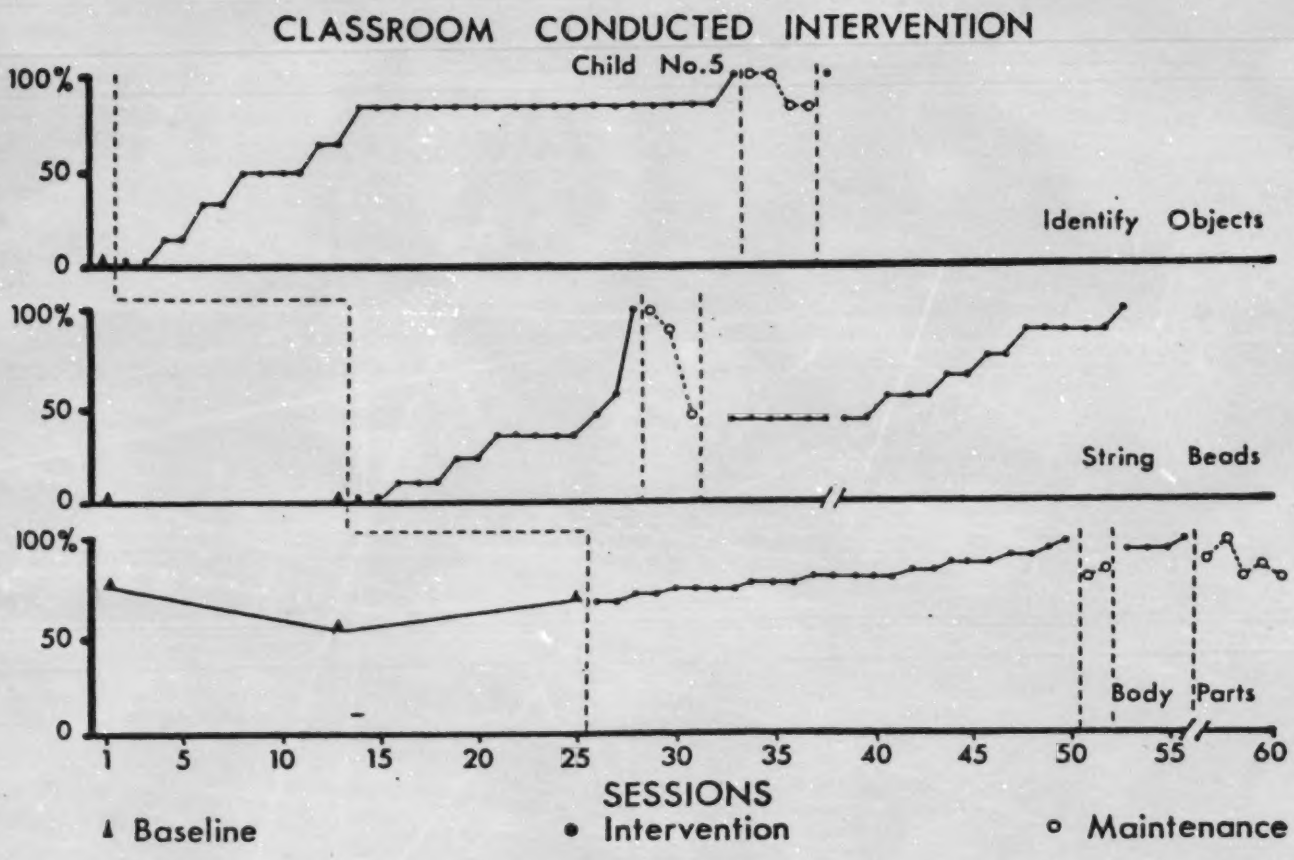
CLASSROOM CONDUCTED INTERVENTION
Child No.5
Percent of Program Skills Acquired
100%
50
0
Identify Objects
String Beads
Body Parts
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention
Maintenance

Figure 9

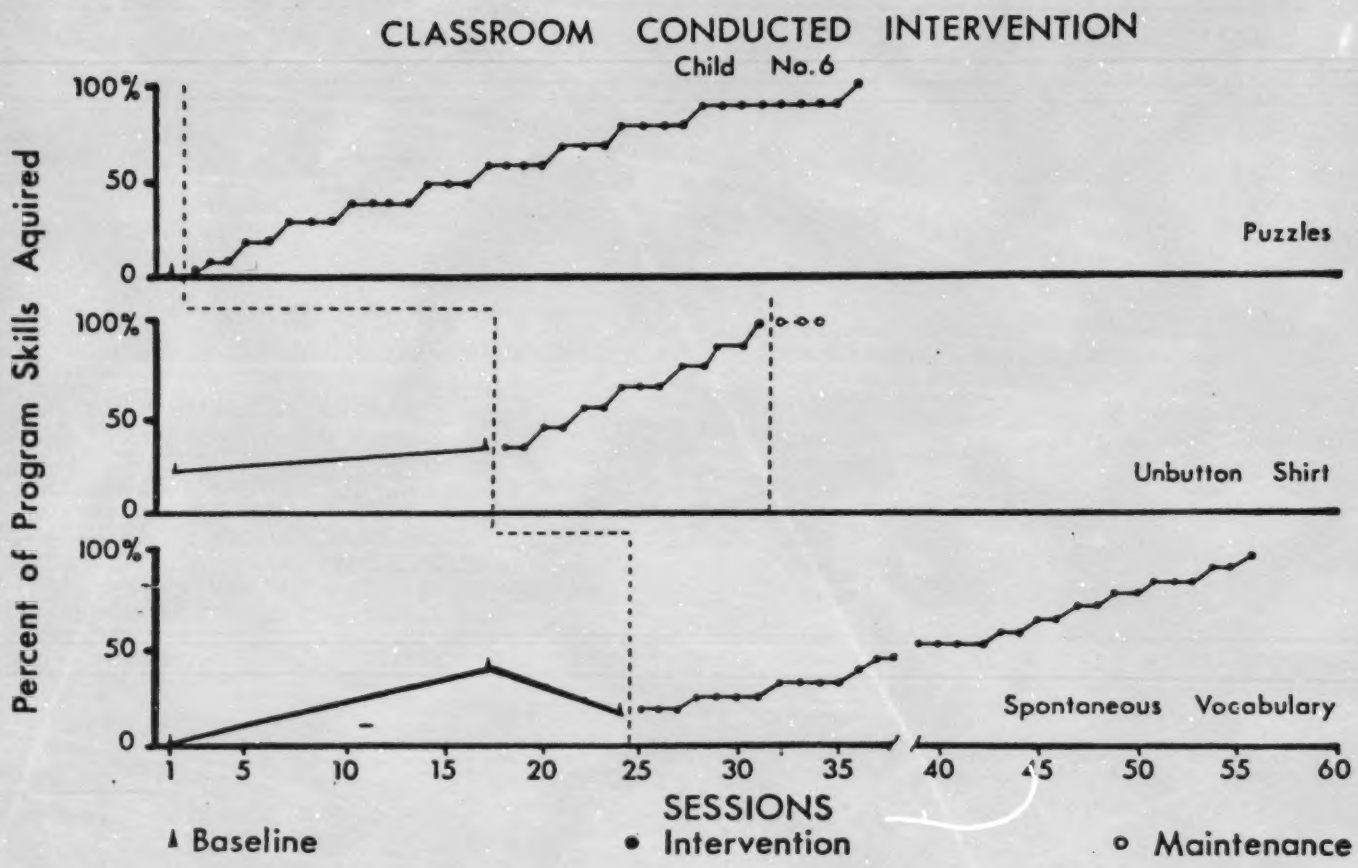
CLASSROOM CONDUCTED INTERVENTION
Child No. 6
Percent of Program Skills Aquired
100%
50
0
Puzzles
Unbutton Shirt
Spontaneous Vocabulary
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention
Maintenance

Figure 10

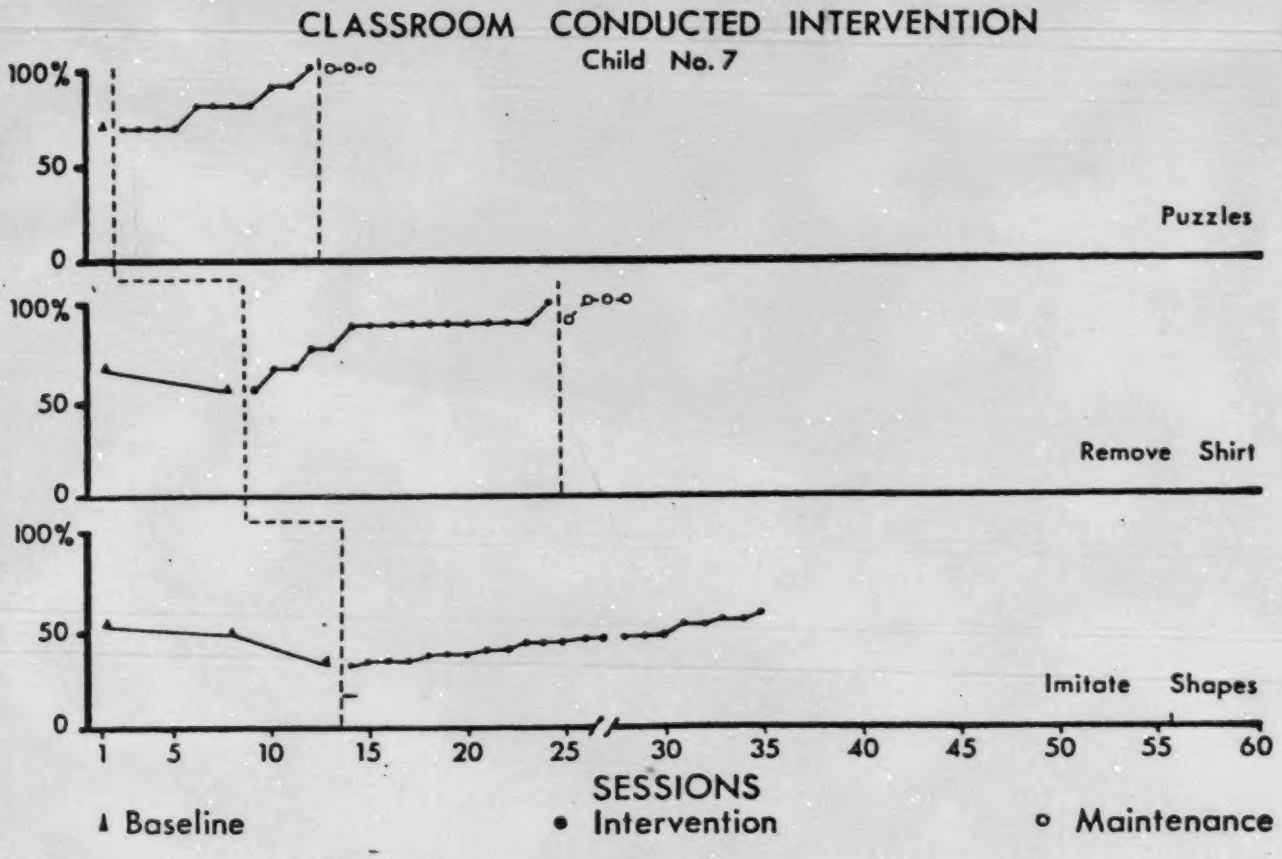
CLASSROOM CONDUCTED INTERVENTION
Child No. 7
100%
50
0
Puzzles
Remove Shirt
Imitate Shapes
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention
Maintenance

Figure 11

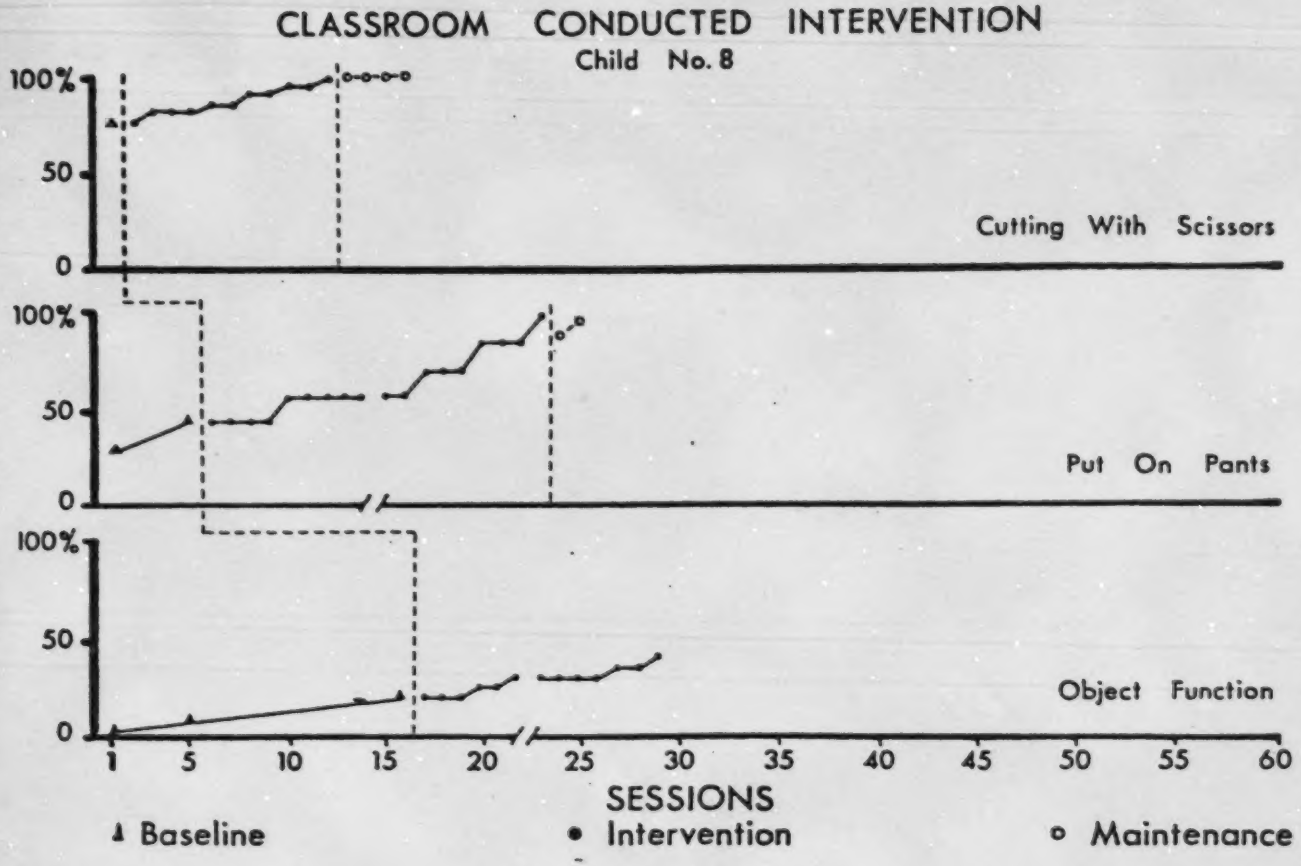
CLASSROOM CONDUCTED INTERVENTION
Child No. 8
100%
50
0
Cutting With Scissors
100%
50
0
Put On Pants
100%
50
0
Object Function
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention
Maintenance

Figure 12

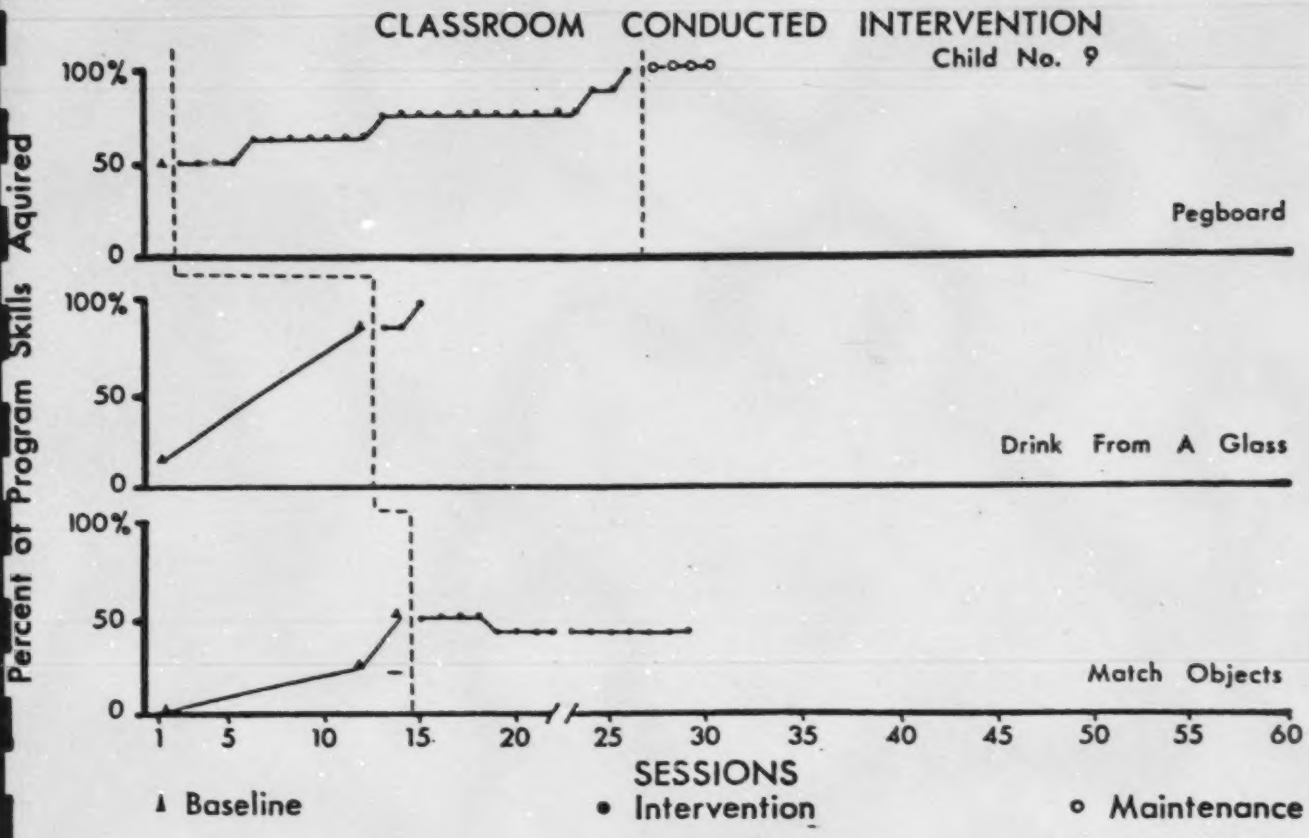
CLASSROOM CONDUCTED INTERVENTION
Child No. 9
Percent of Program Skills Aquired
100%
50
0
Pegboard
Drink From A Glass
Match Objects
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention
Maintenance

Figure 13

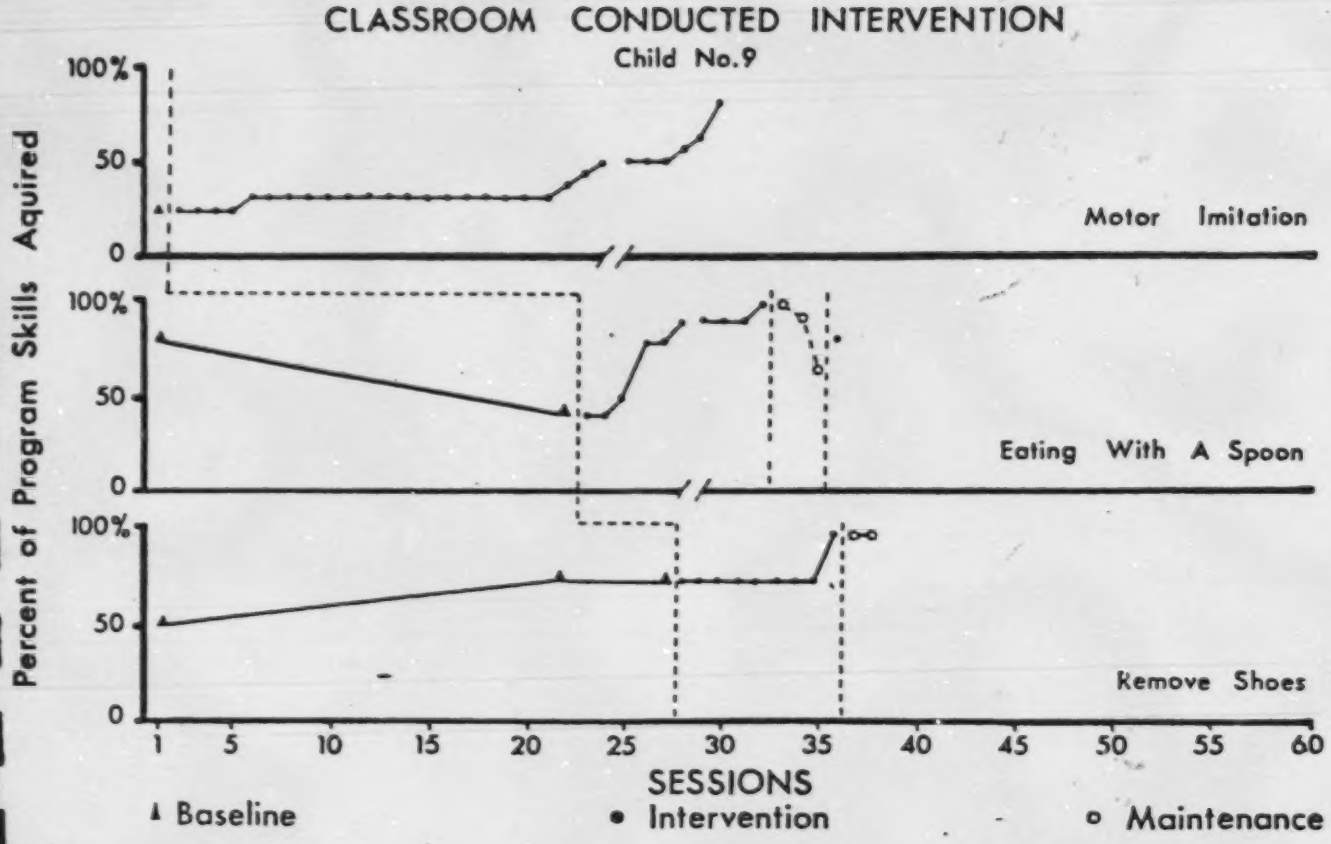
CLASSROOM CONDUCTED INTERVENTION
Child No.9
Percent of Program Skills Aquired
100%
50
0
Motor Imitation
Eating With A Spoon
Remove Shoes
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention
Maintenance

Figure 14

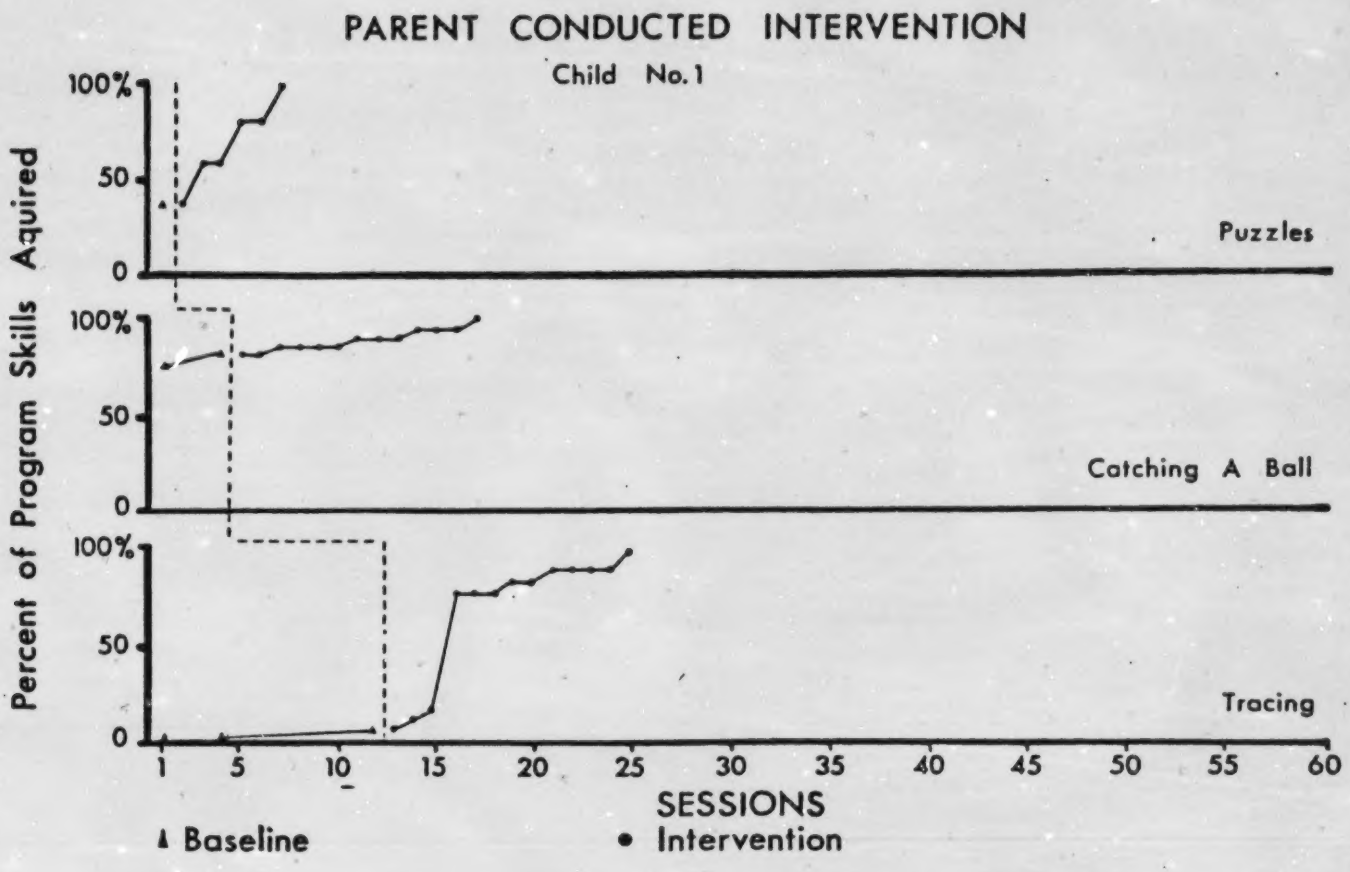
PARENT CONDUCTED INTERVENTION
Child No. 1
Percent of Program Skills Aquired
100%
50
0
Puzzles
Catching A Ball
Tracing
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention

Figure 15

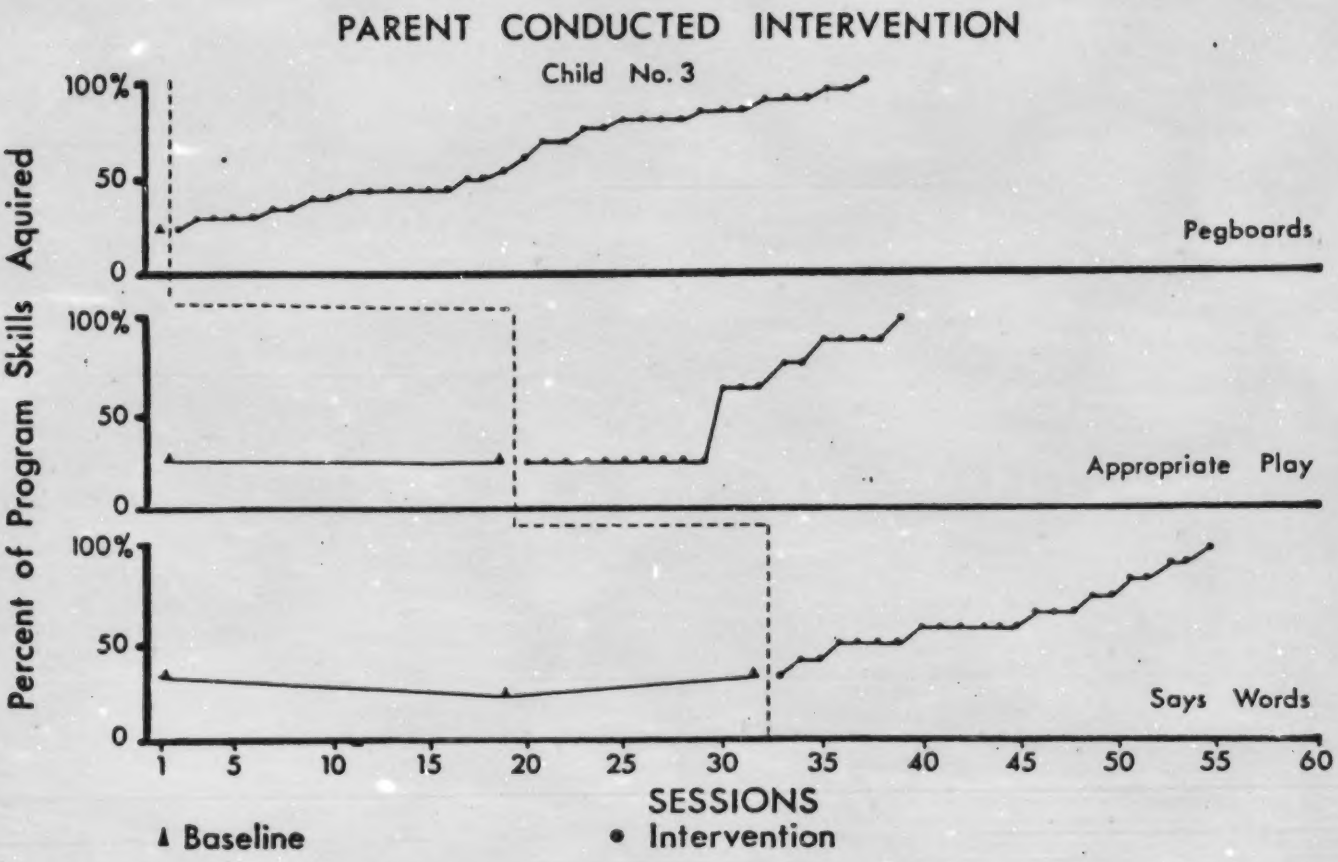
PARENT CONDUCTED INTERVENTION
Child No. 3
Percent of Program Skills Aquired
100%
50
0
Pegboards
Appropriate Play
Says Words
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention

Figure 16

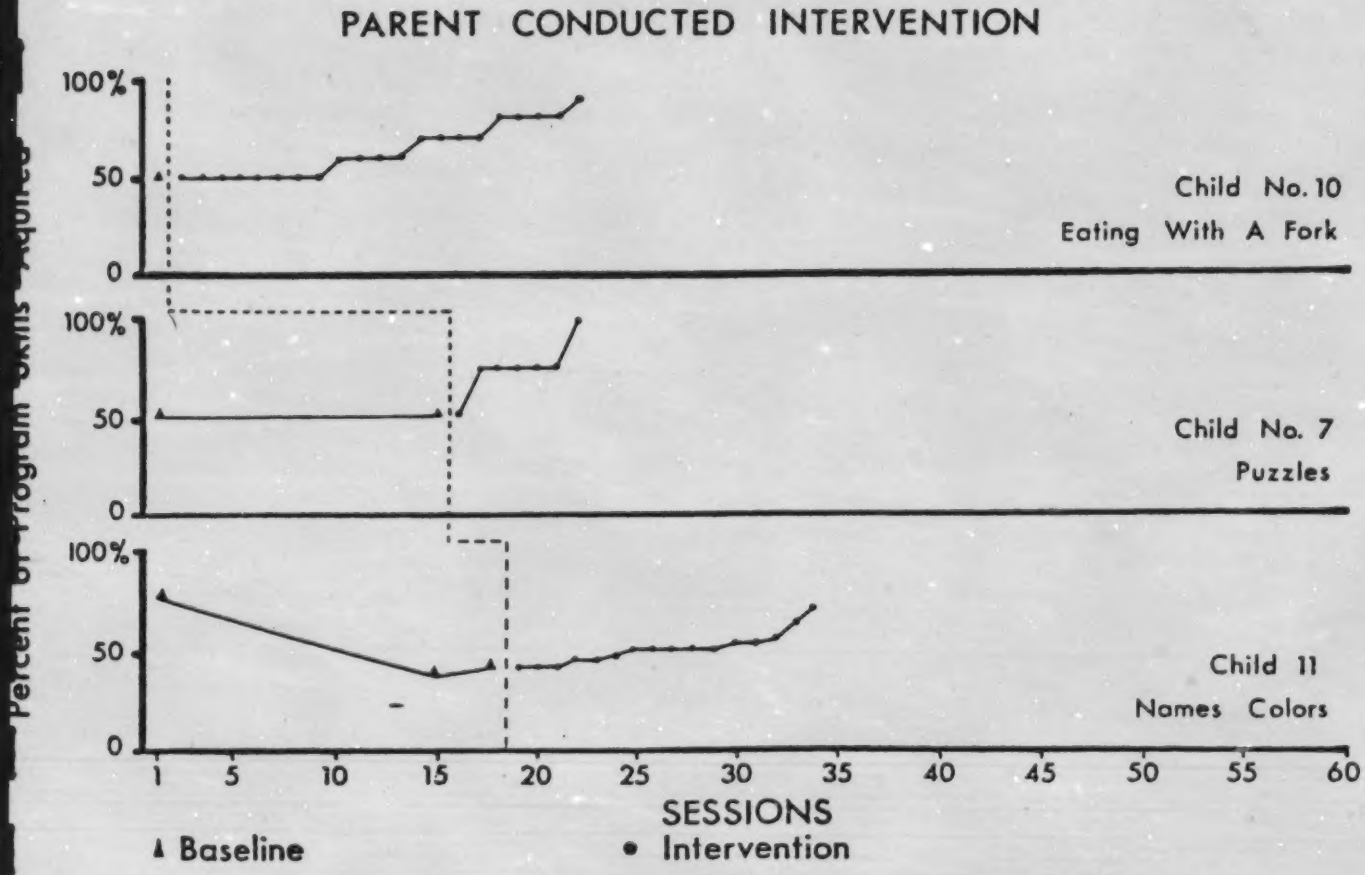
PARENT CONDUCTED INTERVENTION
Percent of Program Skills Acquired
100%
50
0
Child No. 10
Eating With A Fork
Child No. 7
Puzzles
Child 11
Names Colors
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention

Figure 17

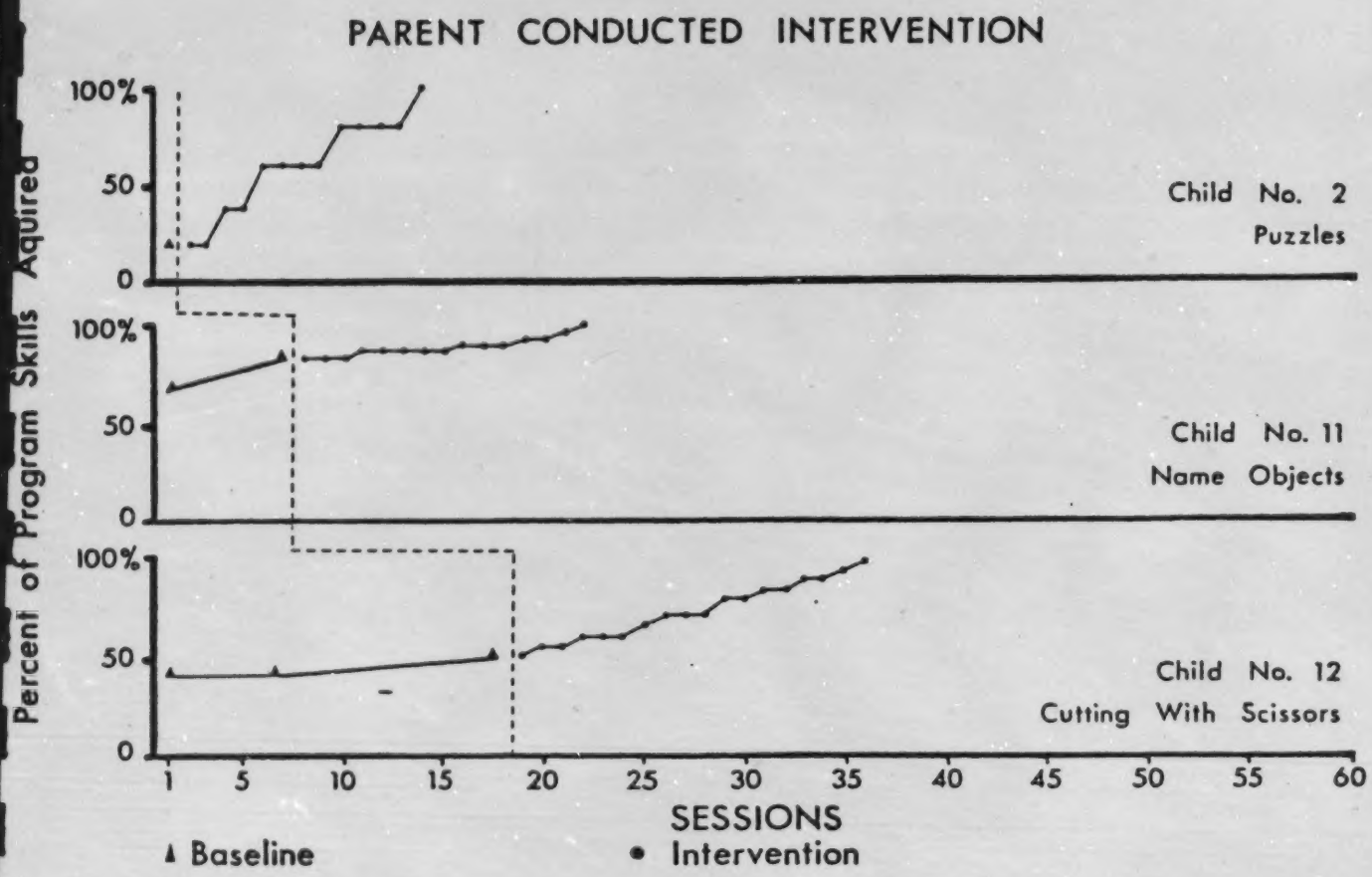
PARENT CONDUCTED INTERVENTION
Percent of Program Skills Aquired
100%
50
0
Child No. 2
Puzzles
Child No. 11
Name Objects
Child No. 12
Cutting With Scissors
1
5
10
15
20
25
30
35
40
45
50
55
60
SESSIONS
Baseline
Intervention

Figure 18

SECTION iv

INSERVICE TRAINING FOR PROJECT STAFF

INSERVICE TRAINING FOR PROJECT STAFF

During this three year project, the staff of the Child Neurology Clinic participated in a number of inservice training activities. In October 1977 several staff members attended a one-week training session at Teaching Research Division in Monmouth, Oregon. The purpose of this training was to help prepare the project staff for training professionals and paraprofessionals in the Teaching Research Data Based Classroom Model. The objectives and outcome of this training were detailed in the six month report submitted during the 2nd year. Additional training of Clinic staff was provided as a result of the working relationship with WESTAR. A technical assistance needs assessment was completed in November 1977. This needs assessment identified some major areas where staff training was desired. Consequently, training activities provided in the areas of a) administration of the Reitan Neuropsychological Assessment Battery and b) utilization of total communication techniques in the classroom. Throughout each year, Clinic staff have participated in workshops, classes, and other types of inservice training activities.

In order to facilitate the continued professional growth and development of Clinic personnel, a staff appraisal system has been implemented. The appraisal system has two primary goals. The first goal is to insure that staff performance is, in fact, assessed on a consistent and ongoing basis. This goal is important not only in terms of the professional growth of staff, it is also important in terms of insuring the continuing development of the educational model. A second goal of the system is to have the performance appraisal process result in the establishment of individualized action plans for future inservice training. The existance of individualized staff training plans will aid in the identification planning, monitoring, and evaluation of inservice activities.

The staff appraisal process involves several phases. The following narrative describes these phases.

Establishment of Critical Areas of Competence

The first phase is the determination of competencies for each educational staff position. These critical skill areas are carefully identified and defined by the educational staff, making sure there was consensus on the part of the staff.

Rating of Staff Performace

The second phase of the system involves the actual rating of performance consistent with the defined areas. A rating sheet has been developed for each position. The actual rating of staff performance involves two steps. First, each staff member rates his/her own performance according to the scales on the rating form. The Educational Coordinator, as the immediate supervisor, also completes a rating form on each staff that she/he directly supervises. Next, on an individual basis, the Educational Coordinator and each staff member meet to discuss and compare the outcome of the rating process. At this point, any discrepancies that exist in the performance ratings are resolved. Typically, discrepancies occurred in areas where responsibilities are not clearly defined in existing documents (i.e. job descriptions) or through delegation of responsibilities not clearly stated.

Development of the Staff Training Plan

Once the rating process is completed, the Director of Educational Services, Educational Coordinator, and staff person being evaluated meet to formulate the individual training plan. A summary form was designed to document this process. The summary form identifies the rating scores, areas of strength, and areas of desired improvement that resulted from the initial staff rating process. From this information, training goals and target date, consistent with each skill area, are determined. The final feature of the training plan is the identification of the resources available to accomplish the specified goals. These resources may be generated from Clinic resources or from other resources available to the staff member. This summary form in its entirety, constitutes the individual inservice training plan for the Clinic's educational program staff.

Monitoring of Training Plans

The performance appraisal of the educational staff is conducted annually. Consequently, the individualized inservice training plan is updated each year. The implementation of the training plans are monitored through the course of the year through a series of meetings.

During the third project year Clinic staff members participated in a broad range of inservice training activities. Inservice training efforts within the Clinic included such areas as speech and language assessment, autobiological assessment procedures, occupational therapy assessment, physical therapy assessment and treatment techniques, and a series of lectures in behavior managment and learning theory. These training sessions were conducted by Clinic members to enhance the effectiveness of the multi-disciplinary approach used at the Clinic through the sharing of information between the different disciplines at the Clinic, staff

learn to relate more effectively to the other professions represented at the Clinic. Other training efforts included training from outside the Clinic setting. An attorney conducted an inservice concerning the legal implications of obtaining informed consent from families, laws on confidentiality, research, and other legal issues pertaining to the activities of the Child Neurology Clinic. The Clinic staff also attended the 30th Western Institute on Epilepsy. Child Neurology Clinic staff members also attended inservice training sessions and conferences outside the Child Neurology Clinic. These training efforts covered topics including assertion training, effective communication, supervision in special education, learning disabilities, brain damage, assessment of people with epilepsy, and counselling for family members of brain damaged patients (see Appendix A).

SECTION IV

INSERVICE TRAINING FOR PROJECT STAFF

APPENDIX A

WORKSHOPS AND CONFERENCES ATTENDED BY CNC STAFF

1. Albert Greenwood, Ph.D., Robert Aungier, and Susan Clark
   Medical Horizons Conference
   "New Approaches to Minimal Brain Damage, Hyperactivity, and Learning Disabilities"

2. Richard D. Charlton, Ph.D., and Albert Greenwood, Ph.D.
   Western Regional American Board of Professional Psychology
   Post-Graduate Institute in Psychology
   "Human Assessment"

3. Albert Greenwood, Ph.D.
   Oregon Psychological Association
   "Counselling Family Members of Characterologically Altered Brain Damaged Patients"

4. Susan Holstrom
   Institute for Managerial and Professional Women
   "Effective Communication"
   State of Oregon Department of Education
   "Supervision in Special Education"
   Infant Hearing Resource Center
   "Assertiveness Training"

PRESENTATIONS BY CHILD NEUROLOGY CLINIC STAFF

1. Susan Cook
   Portland State University
   "Preschool Classrooms at the Child Neurology Clinic"

2. Robert Aungier
   American Association for the Education of Severely and Profoundly Handicapped
   "Evaluating the Educational Prospects of Severely Delayed Children in an Inpatient Psychiatric Unit"

3. Janet Farrell
   American Association for the Education of Severely and Profoundly Handicapped
   "Model of Parent Training"
   American Association of Mental Deficiency
   "Alternate Parent Training Models"
   Workshop, Child Behavior Management

4. Richard D. Charlton, Ph.D., David N. Grove, Ph.D. Co-Presenters
   Oregon Psychological Association
   "Current Research on Neurologically Handicapped Children"

5. Jo Alexander
   Clackamas County Education Service District
   "Models of Parent Training at the Child Neurology Clinic"

6. Robert Shook
   American Association of Mental Deficiency
   "The Oregon Comprehensive Epilepsy Program"

SECTION v

TRAINING FOR PERSONNEL FROM OTHER PROGRAMS OR AGENCIES

TRAINING FOR PERSONNEL FROM OTHER PROGRAMS OR AGENCIES

During the third project year there has been continued progress toward the implementation of the training consortium between the Child Neurology Clinic and the teaching Research project in Monmouth, Oregon. The consortium represents a joint effort to train teachers and professionals from schools and agencies throughout the country in the Child Neurology Clinic Data Based Classroom for the education of developmentally delayed/neurologically impaired children. The first 6 months of the second project year were devoted to the development of training materials, the conversion of the Child Neurology Clinic demonstration classrooms into training classrooms, and the adaptation of the Teaching Research training model to a medical context. During the second 6 month period of the second project year a pilot training program was implemented. During the third project year the training project was successfully implemented in full.

The Child Neurology Clinic Data Based Classroom represents a systematic approach to the teaching of handicapped children. The skills which are taught through this model are subjected to a task analysis whereby each skill is broken down into a series of smaller tasks which may be mastered more easily. This model follows a prescriptive curriculum with a behavioral approach and an emphasis upon individualized instruction. The underlying philosophy of this model is that every child is capable of learning regardless of handicapping condition. Further, handicapped children learn in the same manner as other children although usually at a slower rate.

The curriculum for the data based classroom model encompasses a broad range of skill areas and skill levels. These skill areas include toilet training, basic motor skills, receptive and expressive language, preacademic and academic skills. The approach taken in teaching the child in these areas utilizes behavior modification techniques. Data is taken during each step of the teaching process so that subsequent learning may be quantified and tasks changed accordingly. The collection of data is fundamental to this method of instruction. It provides constant feedback as to the child's ability to perform on any given tasks and serves as an indicator as to when a change in tasks is appropriate.

The role of the teacher in this model is to function as a classroom manager, supervising assistant teachers, volunteers and parents in the classroom and revising the individual prescriptive programs on an ongoing basis. The assistant teachers work directly with the children and keep data which is reviewed daily by the teachers. The teacher then makes changes in the child's individualized instruction program based upon this data. It is the goal of the Child Neurology Clinic/ Teaching Research training consortium to familiarize the trainee with all aspects of the volunteer, assistant teacher and teacher roles in the classroom.

The Teaching Research Project, operating from Monmouth, Oregon has assumed the responsibility for scheduling trainees at the Child Neurology Clinic with a priority given to those individuals from a medical context. The training classrooms at the Child Neurology Clinic emphasize the medical as well as the educational needs of children. These classrooms have been designed primarily for the neurologically impaired child with a strong emphasis upon physical therapy.

As previously mentioned, a pilot training program was implemented during the second 6 month period of the second project year. Training began in January 1978 and proceeded at the rate of approximately three trainees per month through July. Trainees represented eight states including Oregon, Washington, California, New Mexico, Texas, Minnesota, Colorado, and Mississippi. Training continued at this same rate during the third project year. A total of 32 trainees, including 17 practicum students from five colleges, participated in the training process during the third project year.

Typically, training sessions last for one week. A syllabus is provided for each trainee outlining the weeks activities and reading materials (see Appendix A). Mornings typically involve working directly in the classrooms while afternoons have been reserved for instruction. The training format is based upon a series of nine objectives designed to measure the extent to which the trainees learn to use the Child Neurology Clinic data based classroom model (see Appendix B). The trainees are tested prior to training to develop a baseline measure of their understanding of the data based classroom model. The test is administered again following training to assess the extent to which the trainees learned to use the model.

Table I provides a list of trainees from other agencies, who participated in the pilot training project. Of these, 80% met all of the training objectives (see Table I). Trainees are required to meet minimum criteria on each objective to receive credit for that objective. In accordance with the training project guidelines, follow-up visits are to be performed on all trainees by the Child Neurology Clinic, Teaching Research, or by WESTAR depending upon locale and scheduling limitations.

TABLE I

TRAINEES PARTICIPATING IN CNC TRAINING PROGRAM

	Initials	Training Date	Percent of Objectives Met
1.	V.C.	10/16/78	88%
2.	P.H.	12/4/78	100%
3.	L.D.	12/4/78	100%
4.	B.D.	12/4/78	100%
5.	M.W.	1/15/79	87%
6.	S.J.	1/15/79	88%
7.	S.C.	1/15/79	100%
8.	J.A.	5/16/78	100%
9.	L.A.	5/21/78	100%
10.	J.O.	5/21/78	100%
11.	J.C.	5/11/78	100%
12.	B.S.	6/11/79	100%
13.	C.D.	6/11/79	100%
14.	T.W.	6/11/79	100%
15.	L.T.	6/11/79	100%

The training program directed toward the replication of the Child Neurology Clinic data based classrooms has been implemented. The training program has proven to be an effective means of training and is indicative of the Child Neurology Clinic's ability to operate as a training facility. In an effort toward the continuation of these training efforts the Child Neurology Clinic has applied for and received funding through the Bureau of Education for the Handicapped to increase training efforts. Specifically, the Clinic will work in conjunction with Mercy Hospital in Oklahoma City to replicate existing programs in that facility.

The training manual used in training activities at the Child Neurology Clinic is currently under revision to include more representative and comprehensive information to better describe the diagnostic prescriptive classroom model and to include updated information used in the classrooms. The majority of existing training activities, forms, descriptions, and curriculum items presented in the manual will be revised to some extent. Further, there will be significant changes in the training objectives for trainees coming through the program. A broader range of training lectures will be offered to include occupational therapy,

physical therapy, speech and language, and medical information. The greater variety of training activities offered will allow for greater alternatives and flexibility to better meet the needs of the trainees.

Specific components of the training manual which have been revised include a broad range of specific skill training programs to be included in the diagnostic prescriptive classroom curriculum. The placement test is also under revision to better reflect specific skill programs and the sequences of those programs to match the revised Child Neurology Clinic data based classroom curriculum. Revisions also include updated behavior management materials to reflect new approaches developed by the parent trainers at the Child Neurology Clinic.

In addition to the revisions of the training objectives and classroom curriculum items are new data collection and training observation forms which better reflect the revised training and curriculum models. Observation forms for the teacher, assistant teacher, and instructor roles have been modified to more accurately record critical verbal and non-verbal interactions.

SECTION v

APPENDIX A

CHILD NEUROLOGY CLINIC TEACHER OBSERVATION FORM (10 Minute Observation)

Teacher: _____ Observer: _____ Date, Time: _____

ROLE BEHAVIORS

30 Second Time Sample

	APPROPRIATE				INAPPROPRIATE		
	INTERACTING	MODELING	OBSERVING	ADMIN. SCHEDULING, ETC.	NOT ATTENDING TO PRIORITY SITUATION	OTHER	TOTAL
ASSISTANT TEACHER							
INSTRUCTORS							
CHILD							
_____							
TOTAL							

APPROPRIATE ROLE BEHAVIORS / TOTAL ROLE BEHAVIORS = _____ = _____%

VERBALIZATIONS

Continuous Time Sample

	COMMANDS		QUESTIONS		DESCRIPTIONS		REINFORCERS	
	APPRO-PRIATE	IN-APPRO-PRIATE	APPRO-PRIATE	IN-APPRO-PRIATE	APPRO-PRIATE	IN-APPRO-PRIATE	APPRO-PRIATE	IN-APPRO-PRIATE
ASSISTANT TEACHER								
INSTRUCTORS								
CHILD								
_____								
TOTAL								

APPROPRIATE VERBALIZATIONS / TOTAL VERBALIZATIONS = _____ = _____%

TOTAL VERBALIZATIONS / 10 MINUTES = _____ VERBALIZATIONS PER MINUTE

ADDITIONAL COMMENTS:	YES	NO	N/A
1. All programs scheduled to be run			
2. Instructors are kept on schedule			
3. Adjusts schedule when necessary			
4. Available and eager to assist staff			
5. Remains composed and pleasant			
6. Circulating and rotating attention			
7. Observes programs as needed			

NOTES:

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As adapted from a form developed at Teaching Research Infant and Child Center, Monmouth, Oregon

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CHILD NEUROLOGY CLINIC ASSISTANT TEACHER OBSERVATION FORM (10 Minute Observation)

Trainee: _____ Observer: _____ Date: _____ Time: _____

2 Minute Sample | Continuous Time Sample

	Rotates Attention		DESCRIPTORS		CUES				CONSEQUENCES												
									Positive Reinforcers					Correction Procedures							
	YES	NO	Appro-priate	Inappro-priate	Appro-priate	No Cue	Weak	Repeated	Appro-priate	No Rein-forcer	Weak	Delayed	Inappro-priate	Appro-priate	No Correction	Delayed	Inappro-priate	No	Cue	Physical Assist	Social Reinforce
2 Minutes																					
4 Minutes																					
6 Minutes																					
8 Minutes																					
10 Minutes																					

Descriptors:

Appropriate / Total ___ = ___%

Cues:

Appropriate / Total ___ = _____ %

Consequences:

Appropriate / Total ___ = _____ %

Ratio of Positive Reinforcers to Corrections

$\frac{+}{-}$ = _____ = _____

FEEDBACK:

1. _____
2. _____
3. _____
4. _____
5. _____

As adapted from a form developed at Teaching Research Infant and Child Center, Monmouth, Oregon

CHILD NEUROLOGY CLINIC INSTRUCTOR OBSERVATION FORM

TRAINEE _____ OBSERVER _____

PROGRAM _____ DATE _____

CHILD _____ TIME _____

	CUES					CONSEQUENCES												DATA	
						POSITIVE REINFORCERS					CORRECTION PROCEDURES								
	Appropriate	No Cue	Weak	Change Wording	Repeat	Appropriate	No Reinforcer	Weak	Delayed	Inappropriate	Appropriate	No Correction	Delayed	Inappropriate	No	Cue	Physical Assist	Social Reinforce.	Appropriate	Inappropriate
Program																				
Non-Program																				

COVER SHEET INFORMATION:

1. Verbal Cue:
2. Non-verbal Cue:
3. Phase and Step Description:
4. Criterion:
5. Correction Procedure:
6. Reinforcer:

FEEDBACK TO TRAINEE:

1. _____
2. _____
3. _____

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CUES: Appropriate / Total ____ = _____ %

CONSEQUENCES: Appropriate / Total ____ = _____ %

DATA: Appropriate / Total ____ = _____ %

As adapted from a form developed at Teaching Research Infant and Child Center, Monmouth, Oregon

PART III

INCIDENT DATA

zines, journals, etc.; papers prepared for professional meetings; textual and graphic materials; completed curriculum materials and instructional guides, or drafts if in a developmental stage, special methods, techniques and models developed; scales and other measuring devices used.

When finished with this portion of Part II, 13.443 grantees go to C of Part II.

C. All grantees are to respond to this section C. Discuss the following:

(1) Unanticipated or anticipated spinoff developments *(i.e., those which were not part of your originally approved subobjectives, but which are contemplated within the purpose of the Education for the Handicapped legislation, such as new cooperative inter-agency efforts, a decision by volunteer(s) to pursue a career in special education, new public school policy to integrate handicapped children into regular classrooms, enactment of mandatory or other State legislation affecting early education, relevant new course offerings at universities, etc.).*

(2) Where outputs are quantified in response to any portion of Part II, relate quantifications to cost data for computation of unit costs. Analyze and explain high-cost units.

(3) Indicate other matters which you would like OE to know about *(e.g., community response to the project, matters concerning the project's working relationship with OE, technical assistance of OE staff, or any other relevant subject.).*

Part III

All grantees with a Demonstration/Service function or activity, except for 13.444 grantees who are solely supported for "outreach" activities, are to complete Tables IA, IB, and IC. All grantees under 13.451, as well as those under other handicapped programs with a Preservice/Inservice Training activity are to complete Table II. All grantees under 13.444 except those who are supported solely for "outreach" activities, are to complete Tables IIIA and IIIB.

Table IA – Demonstration/Service Activities Date

Children

Enter actual performance data for this report period into the appropriate boxes. Use age as of the time of the original application, or the continuation application, whichever is later. On lines above line 11, count multihandicapped individuals only once, by primary handicapping condition, and indicate the number of multihandicapped in line 12. Data for lines 1 through 11 are for those directly served: i.e., services to those enrolled or receiving major services, and not those merely screened, referred or given minimal or occasional services.

Type of Handicap	Number of Handicapped Served by Age					
	Ages 0-2	Ages 3-5	Ages 6-9	Ages 10-12	Ages 13-18	Age 19 and Over
1. Trainable Mentally Retarded	5	12				
2. Educable Mentally Retarded		6				
3. Specific Learning Disabilities						
4. Deaf-Blind	2					
5. Deaf/Hard of Hearing	2					
6. Visually Handicapped	4					
7. Seriously Emotionally Disturbed	4	1				
8. Speech Impaired		1				
9. Other Health Impaired	6	5				
10. Orthopedically Impaired	2					
11. Total	25	24				
12. Multihandicapped	7	13				

If the data in the above table differ by more than 10 percent from the data originally presented in your approved application, please explain the difference.

Table IB

Project Staff Providing Services to Recipients in Table IA

Type of Staff	Number	
	Full-time	Part-time *(As Full-time Equivalents)*
Professional Personnel *(excluding teachers)*	5	
Teachers	4	
Paraprofessional	3	

Table IC

If applicable: Services to Those Handicapped Not Included in Table IA

Service	Number of Handicapped
Screened	21
Diagnostic and Evaluative	244
Found to Need Special Help	244
Other Resource Assistance	21

Table II

Preservice/Inservice Training Data

Handicapped Area of Primary Concentration	Number of Persons Received Inservice Training	Number of Students Received Preservice Training by Degree Sought:			
		AA	BA	MA	Post-MA
Multihandicapped	15				
Administration					
Early Childhood					
Trainable Mentally Retarded					
Educable Mentally Retarded					
Specific Learning Disabilities					
Deaf/Hard of Hearing					
Visually Handicapped					
Seriously Emotionally Disturbed					
Speech Impaired					
Orthopedically and Other Health Impaired					
TOTAL	15				

If data in Table II above differ by more than 10 percent from those in your approved application, explain.

Table IIIA
Placement of Children Participating in Early Childhood Program During Reporting Period

Indicate the placement of children who left your project during the year covered by this report period.
NOTE: Count each child only once by primary type of placement below.

TYPE OF PLACEMENT			NUMBER OF CHILDREN	
			FULL-TIME	PART-TIME
INTEGRATED PLACEMENT *(i.e., in regular programs with children who are NOT handicapped)*	Nursery schools		10	
	Day-care programs			
	Head Start		2	
	Pre-kindergarten			
	Kindergarten			
	Primary grades	First	2	
		Second		
		Other		
SPECIAL EDUCATION PLACEMENT *(i.e., in classes only for handicapped children but situated in regular private or public school)*	Pre-kindergarten		1	
	Kindergarten		4	
	Primary grades	First	2	
		Second		
		Other		
INSTITUTIONAL PLACEMENT	Scheduled to remain in Early Childhood Program in coming year		16	
	Other *(specify)* Institutional Placement		1	

Table IIIB

	NUMBER		PERCENT
Cumulative number of children entered into integrated placement *(if known)* prior to this report period →		Estimated retention rate of cumulative number in integrated placement →	32 %

PART IV

FINANCIAL STATUS REPORT

FINANCIAL STATUS REPORT

(Follow instructions on the back)

1. FEDERAL AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH REPORT IS SUBMITTED	Department of Health, Education and Welfare Grants and procurement Management Division
2. FEDERAL GRANT OR OTHER IDENTIFYING NUMBER	02 G007602087
OMB Approved No. 80-R0180	
PAGE OF PAGES	
3. RECIPIENT ORGANIZATION (Name and complete address, including ZIP code)	Good Samaritan Hospital & Medical Center 1015 N. W. 22nd Portland, Oregon 97210
4. EMPLOYER IDENTIFICATION NUMBER	93-0386793-H
5. RECIPIENT ACCOUNT NUMBER OR IDENTIFYING NUMBER	7406
6. FINAL REPORT	[X] YES [ ] NO
7. BASIS	[ ] CASH [X] ACCRUAL
8. PROJECT/GRANT PERIOD (See instructions) FROM (Month, day, year)	7/1/76
TO (Month, day, year)	6/30/79
9. PERIOD COVERED BY THIS REPORT FROM (Month, day, year)	7/1/78
TO (Month, day, year)	6/30/79

10. STATUS OF FUNDS

PROGRAMS/FUNCTIONS/ACTIVITIES ►	(a) Payroll	(b) Instructional Supplies	(c) Office Supplies	(d) Travel	(e) Training	(f) Space Lease	TOTAL (Continued)
a. Net outlays previously reported	$ 121,101	$ 2,917	$ 5,076	$ 1,803	$ 3,215	$ 3,264	$
b. Total outlays this report period	90,712	1,064	1,012	2,915	1,034	9,666	
c. *Less:* Program income credits	-0-	-0-	-0-	-0-	-0-	-0-	
d. Net outlays this report period *(Line b minus line c)*	90,712	1,064	1,012	2,915	1,034	9,666	
e. Net outlays to date *(Line a plus line d)*	211,813	3,981	6,088	4,718	4,249	12,930	
f. *Less:* Non-Federal share of outlays	-0-	-0-	-0-	-0-	-0-	-0-	
g. Total Federal share of outlays *(Line e minus line f)*	211,813	3,981	6,088	4,718	4,249	12,930	
h. Total unliquidated obligations	-0-	-0-	-0-	-0-	-0-	-0-	
i. *Less:* Non-Federal share of unliquidated obligations shown on line h	-0-	-0-	-0-	-0-	-0-	-0-	
j. Federal share of unliquidated obligations	-0-	-0-	-0-	-0-	-0-	-0-	
k. Total Federal share of outlays and unliquidated obligations	211,813	3,981	6,088	4,718	4,249	12,930	
l. Total cumulative amount of Federal funds authorized	211,813	3,981	6,088	4,718	4,249	12,930	
m. Unobligated balance of Federal funds	-0-	-0-	-0-	-0-	-0-	-0-	

11. INDIRECT EXPENSE	a. TYPE OF RATE *(Place "X" in appropriate box)* [ ] PROVISIONAL [ ] PREDETERMINED [ ] FINAL [ ] FIXED	b. RATE	c. BASE	d. TOTAL AMOUNT	e. FEDERAL SHARE
		12.5	106,667	13,333	13,333

12. REMARKS: *Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation.*

13. CERTIFICATION

I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL: Robert M. Shook

DATE REPORT SUBMITTED: 11-19-79

TYPED OR PRINTED NAME AND TITLE: Robert M. Shook, Director

TELEPHONE (Area code, number and extension)

269-102

STANDARD FORM 269 (7-76)
Prescribed by Office of Management and Budget
Cir. No. A-110

FINANCIAL STATUS REPORT

(Follow instructions on the back)

1. FEDERAL AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH REPORT IS SUBMITTED	2. FEDERAL GRANT OR OTHER IDENTIFYING NUMBER	OMB Approved No. 80-R0180	PAGE OF PAGES

3. RECIPIENT ORGANIZATION (Name and complete address, including ZIP code)	4. EMPLOYER IDENTIFICATION NUMBER	5. RECIPIENT ACCOUNT NUMBER OR IDENTIFYING NUMBER	6. FINAL REPORT ☒ YES ☐ NO	7. BASIS ☐ CASH ☐ ACCRUAL
	8. PROJECT/GRANT PERIOD (See instructions) FROM (Month, day, year)	TO (Month, day, year)	9. PERIOD COVERED BY THIS REPORT FROM (Month, day, year)	TO (Month, day, year)

10. PROGRAMS/FUNCTIONS/ACTIVITIES ►	STATUS OF FUNDS (a) Other	(b) Capital Outlay	(c) Indirect	(d)	(e)	(f)	TOTAL (g)
a. Net outlays previously reported	$ 12,862	$ 1,000	$ 25,802	$	$	$	$ 177,040
b. Total outlays this report period	264	-0-	13,333				120,000
c. *Less:* Program income credits	-0-	-0-	-0-				-0-
d. Net outlays this report period *(Line b minus line c)*	264	-0-	13,333				120,000
e. Net outlays to date *(Line a plus line d)*	13,126	1,000	39,135				297,040
f. *Less:* Non-Federal share of outlays	-0-	-0-	-0-				-0-
g. Total Federal share of outlays *(Line e minus line f)*	13,126	1,000	39,135				297,040
h. Total unliquidated obligations	-0-	-0-	-0-				-0-
i. *Less:* Non-Federal share of unliquidated obligations shown on line h	-0-	-0-	-0-				-0-
j. Federal share of unliquidated obligations	-0-	-0-	-0-				-0-
k. Total Federal share of outlays and unliquidated obligations	13,126	1,000	39,135				297,040
l. Total cumulative amount of Federal funds authorized	13,126	1,000	39,135				297,040
m. Unobligated balance of Federal funds	-0-	-0-	-0-				-0-

11. INDIRECT EXPENSE	a. TYPE OF RATE *(Place "X" in appropriate box)* ☐ PROVISIONAL ☐ PREDETERMINED ☐ FINAL ☐ FIXED			
	b. RATE	c. BASE	d. TOTAL AMOUNT	e. FEDERAL SHARE

12. REMARKS: *Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation.*

13. CERTIFICATION

I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	DATE REPORT SUBMITTED
TYPED OR PRINTED NAME AND TITLE	TELEPHONE *(Area code, number and extension)*

269-102

STANDARD FORM 269 (7-76)
Prescribed by Office of Management and Budget
Cir. No. A-110